Filing at a Glance

Company:	BEST Life and Health Insurance Company
Product Name:	Group Stand Alone Dental
State:	Tennessee
TOI:	H10G Group Health - Dental
Sub-TOI:	H10G.000 Health - Dental
Filing Type:	Form/Rate
Date Submitted:	04/30/2013
SERFF Tr Num:	BLHI-129004056
SERFF Status:	Assigned
State Tr Num:	H-130558
State Status:	Assigned - Pending Review
Co Tr Num:	FORM FILING
Implementation Date Requested:	01/01/2014
Author(s):	Paul Peatross, Margie Mergen
Reviewer(s):	Vicky Stotzer (primary), Brian Hoffmeister, Melissa Merritt
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:
G SHOP DEN P
GPD-PPO-POL-0113TN
group SHOP dental plan - adult and pediatric

State: *Tennessee* **Filing Company:** *BEST Life and Health Insurance Company*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *Group Stand Alone Dental*
Project Name/Number: *Form Filing/Exchange Products*

General Information

Project Name: Form Filing
Project Number: Exchange Products
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Trust
Filing Status Changed: 05/01/2013
State Status Changed: 05/01/2013
Created By: Margie Mergen
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments: BEST Life is domicilied in Texas. This filing has not been submitted in Texas.
Market Type: Group
Group Market Size: Small
Overall Rate Impact:

Deemer Date:
Submitted By: Margie Mergen

Filing Description:
BEST Life and Health Insurance Company – NAIC No. 90638
FEIN: 95-6042390

List of Forms:
GAD-PPO-POL-0113TN - Group Adult Dental Policy
GAD-PPO-CERT-0113TN - Group Adult Dental Certificate
GAD-PPO-SOV-0113TN - Group Adult Dental Statement of Variability
GAD-PPO-EAP-0113TN - Group Employer Application
GPD-PPO-POL-0113TN - Group Pediatric Dental Policy
GPD-PPO-CERT-0113TN - Group Pediatric Dental Certificate
GPD-PPO-SOV-0113TN - Group Pediatric Dental Statement of Variability

Dear Sir or Madam,

On behalf of BEST Life and Health Insurance Company, please find enclosed the Forms Filing . This filing is to meet the requirements for offering stand alone dental in the Tennessee Exchange. Our filing includes 2 products for the Small Group Market. These forms do not replace previously filed forms and do not deviate from generally accepted standard insurance practices.

These stand alone dental plans are being offered through the Beneficial Employees Security Trust, which is situsedin Utah. The forms will correspond to the following Exchange markets as follows:

For the SHOP Market:
- Pediatric Only EHB Dental Plan: - GPD-PPO-CERT-0113TN
- Adult (without Pediatric EHB) - GAD-PPO-CERT-0113TN

Should you have any questions or concerns regarding this filing, please contact me directly at the number listed below or via email. I appreciate your time and consideration.

Sincerely,

State: *Tennessee* ***Filing Company:*** *BEST Life and Health Insurance Company*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *Group Stand Alone Dental*
Project Name/Number: *Form Filing/Exchange Products*

Margie Mergen
Compliance Analyst
BEST Life and Health Insurance Company
1-800-433-0088, ext. 226
Fax: 949-222-1004
Email: mmergen@bestlife.com

Company and Contact

Filing Contact Information

Paul Peatross, Senior Vice President
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Irvine, CA 92614

ppeatross@bestlife.com
949-222-2118 [Phone]

Filing Company Information

BEST Life and Health Insurance Company
2505 McCabe Way
Irvine, CA 92623
(800) 433-0088 ext. [Phone]

CoCode: 90638
Group Code:
Group Name:
FEIN Number: 95-6042390

State of Domicile: Texas
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	Yes
Fee Explanation:	Texas has a $100 filing fee
Per Company:	No

Company	Amount	Date Processed	Transaction #
BEST Life and Health Insurance Company	$100.00	04/30/2013	69862488

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Form Schedule

Lead Form Number: GPD-PPO-POL-0113TN

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		GROUP POLICY	GAD-PPO-POL-0113TN	POL	Initial			GAD-PPO-POL-0113TN.pdf
2		CERTIFICATE	GAD-PPO-CERT-0113TN	CER	Initial		43.500	GAD-PPO-CERT-0113TN.pdf
3		VARIABILITY STATEMENT	GAD-PPO-SOV-0113TN	MTX	Initial			GAD-PPO-SOV-0113TN.pdf
4		GROUP POLICY	GPD-PPO-POL-0113TN	POL	Initial			GPD-PPO-POL-0113TN.pdf
5		CERTIFICATE	GPD-PPO-CERT-0113TN	CER	Initial		43.500	GPD-PPO-CERT-0113TN.pdf
6		VARIABILITY STATEMENT	GPD-PPO-SOV-0113TN	MTX	Initial			GPD-PPO-SOV-0113TN.pdf
7		EMPLOYER APPLICATION	GAD-PPO-EAP-0113TN	AEF	Initial			GAD-PPO-EAPP-0113TN.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Group Insurance Policy

Dental PPO Plan

[2505 McCabe Way
Irvine, California 92614]

Notice to Buyer: This Policy provides dental coverage only.

GAD-PPO-POL-0113TN

BEST Life and Health Insurance Company
[2505 McCabe Way
Irvine, California 92614]

A STOCK COMPANY
(Herein called the Company)

BEST Life and Health Insurance Company, in consideration of the application of the Subscribing Employer and the payment of premiums as due, agrees, subject to the terms and conditions of this Group Policy, to insure Eligible Employees of Subscribing Employers to the Group Policyholder and their eligible Dependents under this Group Policy.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Utah. Its terms are governed by and shall be construed in accordance with the laws of the Governing Jurisdiction.

This Group Policy becomes effective at 12:01 a.m., Standard Time at the office of the Group Policyholder on the Group Policy Effective Date in the State of Delivery specified below. Subject to the terms and conditions of this Group Policy, it can be renewed until the First Renewal Date by timely payment of the required premium by the Group Policyholder. Unless terminated in accordance with the applicable provision of this Group Policy, it can be renewed after such time from month to month, subject to the terms and conditions of this Group Policy, by timely payment of the required premium.

NOTICE OF TEN DAY RIGHT TO EXAMINE: We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Group Policy to the agent or to Our home office within ten days of receipt and the premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

This Group Policy may be modified by mutual agreement between the Group Policyholder and Us.

The provisions and the terms in the Certificate are part of this Group Policy. A copy of the Certificate is attached to, and made a part of this Group Policy.

Signed for **BEST Life and Health Insurance Company** by its President and Secretary at [2505 McCabe Way, Irvine, California 92614.]

[ ][

President Secretary

Group PPO
Pediatric Dental Policy
Non-Participating

Group Policyholder: Beneficial Employees Security Trust of Utah

Group Policy Effective Date: [XX-XX-XXXX] **Group Policy Number:** [XXX]

State of Delivery: Utah

Premiums Due On: 1st of each month **First Renewal Date:** [XX-XX-XXXX]

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PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [The Trustee of the Beneficial Employees Security Trust of Utah.]

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the [80th or 90th] percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

[

	[PPO Dental High] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[1,000 – 1,500]	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	100%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	90%	80%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	60%	50%
Major Services Waiting Period	12 Months	
Endodontic Services	Basic	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Child Orthodontic Coverage Orthodontic Services Coinsurance Orthodontic Maximums – Calendar Year | Lifetime 12 Month Waiting Period	50% $500 | $1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]

[

	[PPO Dental Mid] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$1,500	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	80%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	80%	80%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	50%	50%
Major Services Waiting Period	12 Months	
Endodontic Services	Major	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Child Orthodontic Coverage Orthodontic Services Coinsurance Orthodontic Maximums – Calendar Year | Lifetime 12 Month Waiting Period	50% $500 | $1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]

[

	[PPO Dental Basic] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$1,000	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	80%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	80%	50%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	0%	0%
Endodontic Services	Major	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]
[

	[PPO Dental Value] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$1,000	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	80%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	50%	20%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	0%	0%
Endodontic Services	Major	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]

[**Major Dentistry Waiting Period Waiver**
The twelve (12) month waiting period for Major Dental Procedures is waived if "Yes" is indicated after "Waiting Period Waived on Major Dentistry" on the Statement of Coverage.

This Waiver only applies if the Participating Employer is replacing comparable existing dental coverage that was in force for at least twelve (12) consecutive months immediately prior to the Effective Date of this Plan's coverage and the Employee has been covered: (a) under the prior dental plan for a period of twelve (12) consecutive months; (b) twelve (12) months between the Employee's prior Employer's dental plan and this plan; or (c) twelve (12) months under this dental plan, whichever occurs first.

The Waiver of this waiting period does NOT apply to: (a) the Employee's eligible dependents who were not covered for a period of at least twelve (12) consecutive months between the employer's prior dental plan and this dental plan, or twelve (12) months under this dental plan, whichever occurs first, or (b) the Employee's eligible dependents whose effective date of coverage under this plan is later than the Employees' effective date of coverage.

Waiver of the waiting period shall not be construed to alter any provisions of the Major Dental Procedures.]

PART 2 - BENEFITS

Covered Services

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS I - Preventive Dental Procedures include:

(1) Routine oral examination and diagnosis not more often than twice every 12 months per individual;
(2) Bitewing x-rays not more often than once every 12 months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five years; any combination of eight or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six months per individual.

CLASS II - Basic Dental Procedures include:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
    (a) erupted tooth;
    (b) soft tissue impaction;
    (c) partial bony impaction;
    (d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two quadrants per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
    (a) root recovery (surgical removal of residual root);
    (b) oral antral fistula closure;
    (c) removal of a dentigerous or odontogenic cyst;
    (d) incision and drainage of an abscess;
    (e) removal of lateral exostosis;
    (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

CLASS III - Major Dental Procedures include:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within 12 months after the extraction and while this coverage is in force;

(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
   (a) accidental injury requiring oral surgical treatment, or
   (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within 12 months of the injury or surgical treatment.
(5) Replacement of a full denture or bridgework if the replacement is made more than seven years after the date of installation, unless:
   (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
   (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
(6) Repair or reline of dentures and bridgework;
(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
   (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
   (b) implant supported prosthetics;
   (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
   (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
   (e) implant maintenance.

[**Note:** Unless the twelve (12) month waiting period requirement for Orthodontic Procedures has been met, the services below are not covered benefits for any treatment that begin during the twelve (12) month period immediately following Your effective date of coverage.]

[**CLASS IV – Orthodontic Procedures Include:**
Provides orthodontic treatment for Dependent children until the end of the month of their 18th birthday, to be payable as follows:

(1) All procedures performed in connection with orthodontic treatment subject to the coinsurance level, Calendar Year and Lifetime Maximum Benefit as defined in the Schedule of Benefits;
(2) Benefits for the initial placement up to [1/3][1/2] of the Lifetime Maximum Benefit Amount, as an initial down payment;
(3) Periodic follow-up visits will be payable on a monthly basis during the scheduled course of orthodontic treatment, up to the Lifetime Maximum Amount;
(4) Orthodontic benefits end once braces are removed or at the cancellation of coverage, whichever comes first.]

Supplemental Dental Accident Benefit

This benefit provides 100% coverage, not subject to deductible or coinsurance, for injury to sound, natural teeth up to a maximum benefit amount of $1,000. Predetermination must be submitted before benefits are payable.

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:

BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
(2) Emergency treatment; or
(3) Oral examination and prophylaxis.

Predetermination is required for the following dental services:

(1) Crowns, Anterior, except with posts or root canal;
(2) Crowns, two (2) or more Posterior, except with posts or root canal;
(3) Inlays or Onlays, two (2) or more, except with posts or root canal;
(4) Laminates;
(5) Anterior composites;
(6) Two (2) or more multiple surfaces;
(7) Bridges – initial or replacement;
(8) Eligible partial dentures – initial or replacement;
(9) Periodontal surgery over $500;
(10) Full bony impactions, two (2) or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible

amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

ORTHODONTIC TREATMENT IN PROGRESS

BEST Life will consider orthodontic treatment in progress for takeover if both the prior employer group and the BEST Life plan include orthodontic coverage, and the Insured has had continuous coverage on the prior group plan. Any Orthodontic Lifetime and Calendar Year Maximum benefits used under the prior plan will be deducted from the BEST Life plan. No orthodontic benefits will be provided where the Lifetime and/or Calendar Year Maximum have been met under the prior plan.

PART 4 – EXCLUSIONS

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
(8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
(9) Implants, implant services and implant supported prosthetics are not covered for patients under the age of 16;
(10) Expenses incurred for veneers and related procedures;
(11) Replacement of a lost or stolen or discarded prosthetic device;

(12) Adjustment, repairs or relines of prostheses for a period of one year from initial placement if the prostheses were paid for under this plan;
(13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
(14) If multiple endodontic treatments are necessary on the same tooth within a period of one year, the allowance will be made for only one procedure;
(15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
(16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
(17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
(18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
(20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
(21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(22) Expenses incurred for congenital or developmental malformations;
(23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the “Schedule of Dental Benefits” section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(27) Expenses that are applied toward satisfaction of a Deductible, if any;
(28) Services and supplies performed outside of the United States of America;
(29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
(30) Expenses for services for which You would not legally have to pay if there were no insurance;
(31) Services not completed on or before the date of termination;
(32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
(34) Expenses incurred for services covered on a pediatric only dental plan.

PART 5 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the

Deductible amount shown on the Schedule of Benefits.

Annual Maximum: The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Dependent: Means:
(1) Your lawful spouse or domestic partner and
(2) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or
(3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

Eligible Employee: Means:
(1) A full-time permanent employee who is:
    (a) permanently employed, working at least thirty (30) hours per week and paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and
    (b) not covered by a collective bargaining agreement which requires Your Participating Employer to make contributions; or
(2) A partner or proprietor actively engaged in the business on a full-time basis.

"Eligible Employee" does not mean an independent contractor, commission salesperson, consultant or a person who is in any manner self-employed.

Family Deductible: The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Grace Period: A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

Insured: The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Group Policy.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Subscriber:

(1) A full-time permanent employee who is permanently employed, working at least thirty (30) hours per week, paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and not covered by a collective bargaining agreement; or

(2) A partner or proprietor in a Subscribing Employer who is actively engaged in the business on a full-time basis.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Subscriber.

PART 6 - COVERAGE EFFECTIVE AND TERMINATION DATES

EFFECTIVE DATE

Employee: If You fill out and sign an enrollment card furnished by Us, Your insurance will take effect

on the later of:
(1) the date Your employer becomes a Participating Employer, if Your enrollment card is received by Us within thirty-one (31) days of that date; or
(2) the first day of the next calendar month following the date You complete one calendar month of active full-time employment for a Participating Employer. Your enrollment card must be received by Us within thirty-one (31) days after You satisfy the waiting period[; or
(3) the date You become a qualified employee.]

If Your enrollment card is received by Us more than thirty-one (31) days after You become eligible, You will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If You are not working full-time on the date Your coverage would otherwise take effect, You will not be covered until You return to active full-time employment.

Dependent: Your Dependent's insurance will take effect on the later of:
(1) the effective date of Your coverage, if You enrolled Your Dependent at the same time You applied for coverage; or
(2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within thirty-one (31) days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than thirty-one (31) days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

TERMINATION OF INSURANCE

The Insured’s coverage will stop on the earliest of the following dates:

(1) the last day of the month in which the Subscriber ceases active employment with the Participating Employer, unless Subscriber is on leave of absence, temporary layoff or total disability. In that case, Subscriber's Participating Employer may continue Insured's coverage by paying the required premium, but not beyond the following limits:
   (a) approved leave of absence, 3 months;
   (b) temporary layoff, the end of the month following the month, in which Subscriber's layoff started; or
   (c) total disability, 3 months;
(2) the last day of the month in which Subscriber ceases to be in a class of Subscriber eligible for insurance;
(3) the date Insured ceases to be in a class eligible for insurance under this plan;
(4) the last day of the month in which Subscriber request Subscriber's coverage to be cancelled;
(5) the day before the due date of any premium that remains unpaid at the end of the grace period;
(6) the date the Group Policy terminates;
(7) the date the Subscriber's Employer ceases to be a Participating Employer;
(8) the date the number of the Participating Employer's Subscribers falls below 2;
(9) the last day of the month in which an Insured ceases to meet the definition of Eligible Dependent; or
(10) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

Dependent: Your dependent's insurance will stop on the earliest of the following dates:
(1) the date Your insurance terminates;
(2) the date You fail to make a contribution for dependent insurance;
(3) the date You cease to be in a class eligible for dependent insurance; or
(4) the last day of the month in which a dependent ceases to meet the definition of "Dependent."

If a dependent child, upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, We will continue coverage as long as Your coverage continues and the child continues to be handicapped and dependent upon You for support.

PART 7 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary.

This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:

- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 8 –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal

premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Group Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the Grace Period.

Termination of Group Policy: We may terminate this Group Policy at any time following the first renewal date by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 9 – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or

(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the Policy.

Right to Contest: After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
    (1) the due date to pay any required premium (if premium is not paid by that date).
    (2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
    (3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
    (4) a date which is:
        1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
        2. 36 months from the date coverage would have terminated, if coverage is

continued for any other reason.

PART 10 – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

PART 11 - SUMMARY PLAN DESCRIPTION SUPPLEMENT

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA), and together with the rest of your Certificate, it forms the Summary Plan Description.

(1) NAME OF PLAN: [Beneficial Employees Security Trust], [P.O. Box 3100, Newport Beach, California 92658-9027].
(2) PLAN IDENTIFICATION NUMBER: [501].
(3) TYPE OF ADMINISTRATION AND TYPE OF WELFARE PLAN: The plan is administered by [BEST Life and Health Insurance Company] located at [2505 McCabe Way, Irvine, California 92614], [(800) 433-0088]. Benefits are insured in accordance with the Group Dental Insurance Policy issued by BEST Life.
(4) AGENT FOR SERVICE: The Chief Legal counsel of BEST Life at [the above address].
(5) TRUSTEE OF THE PLAN: [Wells Fargo Bank, N.A., 180 South Main Street, 2nd Floor, Salt Lake City, Utah 84101].
(6) SOURCE OF PLAN CONTRIBUTION: The contributions necessary to finance the plan are made by the employer and employees.

(7) DATE OF END OF THE PLAN'S FISCAL YEAR: [December 31].

PART 12 - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a request for materials from the Plan and does not receive them within thirty (30) days, one may file suit in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

Underwritten by BEST Life and Health Insurance Company

Group Insurance Policy

Dental PPO Plan

[2505 McCabe Way
Irvine, California 92614]

Notice to Buyer: This Certificate provides dental coverage only.

GAD-PPO-CERT-0113TN

CERTIFICATE OF GROUP INSURANCE

Issued By

BEST Life and Health Insurance Company

A STOCK COMPANY
(Herein called the "We," "Us," "Company" or "BEST Life")

BEST Life and Health Insurance Company certifies that Insureds are covered for the benefits described in this Certificate, subject to the limitations and exclusions of this Certificate and of the Group Policy. The Group Policy is the contract between BEST Life and the Policyholder named on the Schedule of Benefits. The Group Policy may be changed or ended without the consent of or notice to the Certificate holder.

This Certificate replaces any certificate previously issued by BEST Life.

PLAN EFFECTIVE DATE: Insurance is in effect on the date shown on the Certificate Statement of Coverage.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Utah. It shall be construed in accordance with the laws of the issuing State.

BEST Life and Health Insurance Company's President and Secretary signed this at [2505 McCabe Way, Irvine, California 92614].

[ ]

President

[ ]

Secretary

GROUP PPO DENTAL
NON-PARTICIPATING

THIS INSURANCE DOES NOT COVER INJURIES OR ILLNESSES THAT HAPPEN IN THE COURSE AND SCOPE OF EMPLOYMENT. ASK YOUR PARTICIPATING EMPLOYER WHETHER YOU ARE PART OF A WORKERS' COMPENSATION SYSTEM.

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This Certificate Is Not Valid
Unless There Is a Complete Statement of Coverage

Statement of Coverage

DENTAL

INSURANCE SUBSCRIBER NAME: [JOHN D. DOE]
CERTIFICATE EFFECTIVE DATE: [01/01/2014]

INSURED NAME(S) AND EFFECTIVE DATE(S):
[JANE DOE 01/01/2014]
[JON DOE 01/01/2014]

PARTICIPATING EMPLOYER NAME: [CUSTOMER NAME]
PARTICIPATING EMPLOYER NUMBER: [TN00XXX0000XX]

[PLAN: [PPO HIGH]
DEDUCTIBLE: [$50]
ANNUAL MAXIMUM: [$1,000]]

GROUP POLICY No.: [XXXXXXXXX]

TABLE OF CONTENTS

PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [The Trustee of the Beneficial Employees Security Trust of Utah.]

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the 80th percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

[

	[PPO Dental High] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$[1,000 – 1,500]	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	100%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	90%	80%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	60%	50%
Major Services Waiting Period	12 Months	
Endodontic Services	Basic	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Child Orthodontic Coverage Orthodontic Services Coinsurance Orthodontic Maximums – Calendar Year | Lifetime 12 Month Waiting Period	50% $500 | $1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]

[

	[PPO Dental Mid] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$1,500	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	80%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	80%	80%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	50%	50%
Major Services Waiting Period	12 Months	
Endodontic Services	Major	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Child Orthodontic Coverage Orthodontic Services Coinsurance Orthodontic Maximums – Calendar Year | Lifetime 12 Month Waiting Period	50% $500 | $1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]

[

	[PPO Dental Basic] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$1,000	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	80%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	80%	50%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	0%	0%
Endodontic Services	Major	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]
[

	[PPO Dental Value] Plan	
Benefits Description	**In-Network [Network]**	**Out-of-Network**
Employer Contributory or Voluntary	[Employer contributory][Voluntary]	
Annual Maximum	$1,000	
Annual Deductible (Applies to Basic and Major) – 3 Deductible Maximum per Family	$50	
Preventive Care Services Routine oral exam, cleanings, X-rays	100%	80%
Basic Services Filings (amalgam, porcelain & plastic), anterior & posterior composites, anesthesia (general or intravenous sedation), emergency palliative treatment, pathology	50%	20%
Major Services Crowns & gold filings, inlays, onlays & pontics, implants, fixed bridges, complete & partial dentures	0%	0%
Endodontic Services	Major	
Periodontic Services	Major	
Oral Surgery Services	Major	
Dental Accident Benefit	$1,000	
Usual and Customary Reimbursement	Fee Schedule	80th Percentile

]

[Major Dentistry Waiting Period Waiver
The twelve (12) month waiting period for Major Dental Procedures is waived if "Yes" is indicated after "Waiting Period Waived on Major Dentistry" on the Statement of Coverage.

This Waiver only applies if the Participating Employer is replacing comparable existing dental coverage that was in force for at least twelve (12) consecutive months immediately prior to the Effective Date of this Plan's coverage and the Employee has been covered: (a) under the prior dental plan for a period of twelve (12) consecutive months; (b) twelve (12) months between the Employee's prior Employer's dental plan and this plan; or (c) twelve (12) months under this dental plan, whichever occurs first.

The Waiver of this waiting period does NOT apply to: (a) the Employee's eligible dependents who were not covered for a period of at least twelve (12) consecutive months between the employer's prior dental plan and this dental plan, or twelve (12) months under this dental plan, whichever occurs first, or (b) the Employee's eligible dependents whose effective date of coverage under this plan is later than the Employees' effective date of coverage.

Waiver of the waiting period shall not be construed to alter any provisions of the Major Dental Procedures.]

PART 2 - BENEFITS

Covered Services

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

CLASS I - Preventive Dental Procedures include:

(1) Routine oral examination and diagnosis not more often than twice every 12 months per individual;
(2) Bitewing x-rays not more often than once every 12 months per individual;
(3) Full mouth x-rays or panoramic films are limited to once every five years; any combination of eight or more x-rays (including but not limited to bitewings or periapicals/intraorals) will be combined into a full mouth x-ray series;
(4) Prophylaxis not more often than once every six months per individual.

CLASS II - Basic Dental Procedures include:

(1) Pathology;
(2) All fillings other than lab fabricated restorations (composite fillings limited to permanent anterior and posterior teeth);
(3) Emergency palliative treatment;
(4) Limited oral exam not more than once every six months;
(5) Simple extraction, excluding orthodontic extractions unless a orthodontic benefits are a Covered Dental Expense on this Plan;
(6) Surgical extraction, including impaction:
    (a) erupted tooth;
    (b) soft tissue impaction;
    (c) partial bony impaction;
    (d) complete bony impaction;
(7) General anesthesia or intravenous sedation when required for complex oral surgical procedures (partial and complete bony impacted extractions only);
(8) Periodontics (tissues and gums);
(9) Periodontal exam (not in addition to a routine oral exam);
(10) Periodontal maintenance (limited to once every six months per individual following active periodontal treatment) and not on the same visit as a routine prophylaxis;
(11) Periodontal scaling and root planing (limited to once every 36 months and to two quadrants per visit, and not in addition to a routine prophylaxis);
(12) Endodontics (pulp capping and root canal); and
(13) Oral surgery:
    (a) root recovery (surgical removal of residual root);
    (b) oral antral fistula closure;
    (c) removal of a dentigerous or odontogenic cyst;
    (d) incision and drainage of an abscess;
    (e) removal of lateral exostosis;
    (f) frenulectomy.

[**Note:** Unless the twelve (12) month waiting period requirement for Major Dentistry services has been met, the services below are not covered benefits for any treatment that began during the twelve (12) month period immediately following Your effective date of coverage.]

CLASS III - Major Dental Procedures include:

(1) Inlays, onlays, crowns and other lab fabricated restorations (not including veneers);
(2) Porcelain, porcelain fused to metal, or full gold crowns on permanent teeth;
(3) Full or partial dentures or fixed bridgework or adding teeth to an existing denture, if required because of loss of functional natural teeth while the person is covered for this Benefit. The work must be done within 12 months after the extraction and while this coverage is in force;

(4) Replacement or alteration of full or partial dentures or fixed bridgework caused by the following while coverage is in force:
   (a) accidental injury requiring oral surgical treatment, or
   (b) oral surgical treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, provided the replacement or alteration is done within 12 months of the injury or surgical treatment.
(5) Replacement of a full denture or bridgework if the replacement is made more than seven years after the date of installation, unless:
   (a) such replacement is made necessary by the initial extraction of an adjoining functional natural tooth; or
   (b) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of a non-chewing injury while covered;
(6) Repair or reline of dentures and bridgework;
(7) Implants, as an alternative to a fixed prosthetic, (limited to once in a lifetime per site). The cost of the fixed prosthetic will be applied to the total value of the implant and implant-related procedures, not to exceed the cost of the fixed prosthetic:
   (a) the surgical placement of endosteal implant body including healing cap, where the bone and soft tissues are sound and healthy;
   (b) implant supported prosthetics;
   (c) eposteal and transosteal implants will be covered at the cost of the endosteal implant (if performed, member is responsible for additional fees);
   (d) bone grafting and tooth extractions, provided the work is done while this coverage is in force;
   (e) implant maintenance.

[**Note:** Unless the twelve (12) month waiting period requirement for Orthodontic Procedures has been met, the services below are not covered benefits for any treatment that begin during the twelve (12) month period immediately following Your effective date of coverage.]

[**CLASS IV – Orthodontic Procedures Include:**
Provides orthodontic treatment for Dependent children until the end of the month of their 18th birthday, to be payable as follows:

(1) All procedures performed in connection with orthodontic treatment subject to the coinsurance level, Calendar Year and Lifetime Maximum Benefit as defined in the Schedule of Benefits;
(2) Benefits for the initial placement up to [1/3][1/2] of the Lifetime Maximum Benefit Amount, as an initial down payment;
(3) Periodic follow-up visits will be payable on a monthly basis during the scheduled course of orthodontic treatment, up to the Lifetime Maximum Amount;
(4) Orthodontic benefits end once braces are removed or at the cancellation of coverage, whichever comes first.]

Supplemental Dental Accident Benefit

This benefit provides 100% coverage, not subject to deductible or coinsurance, for injury to sound, natural teeth up to a maximum benefit amount of $1,000. Predetermination must be submitted before benefits are payable.

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:

BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:

(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
(2) Emergency treatment; or
(3) Oral examination and prophylaxis.

Predetermination is required for the following dental services:

(1) Crowns, Anterior, except with posts or root canal;
(2) Crowns, two (2) or more Posterior, except with posts or root canal;
(3) Inlays or Onlays, two (2) or more, except with posts or root canal;
(4) Laminates;
(5) Anterior composites;
(6) Two (2) or more multiple surfaces;
(7) Bridges – initial or replacement;
(8) Eligible partial dentures – initial or replacement;
(9) Periodontal surgery over $500;
(10) Full bony impactions, two (2) or more.

We will have thirty (30) days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible

amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

ORTHODONTIC TREATMENT IN PROGRESS

BEST Life will consider orthodontic treatment in progress for takeover if both the prior employer group and the BEST Life plan include orthodontic coverage, and the Insured has had continuous coverage on the prior group plan. Any Orthodontic Lifetime and Calendar Year Maximum benefits used under the prior plan will be deducted from the BEST Life plan. No orthodontic benefits will be provided where the Lifetime and/or Calendar Year Maximum have been met under the prior plan.

PART 4 – EXCLUSIONS

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies begun and not completed prior to the patient's effective date, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Pulp capping, if in conjunction with the installation of inlays, onlays or crowns and fillings or other lab fabricated restorations; including but not limited to inlays, onlays and crowns, preventative tests and examinations diagnostic casts and oral cancer screenings, and expenses incurred for sedative fillings, including charges for prescribed drugs, pre-medication or analgesia;
(8) The initial installation of a prosthetic device (a fixed bridge, implant, or denture), including crowns and inlays which form abutments, to replace teeth missing before You were covered under the Policy, except when it also replaces a tooth that is extracted while covered unless such installation commences after You have remained continuously covered under this plan for at least three years immediately prior to the date such installation commences;
(9) Implants, implant services and implant supported prosthetics are not covered for patients under the age of 16;
(10) Expenses incurred for veneers and related procedures;
(11) Replacement of a lost or stolen or discarded prosthetic device;

(12) Adjustment, repairs or relines of prostheses for a period of one year from initial placement if the prostheses were paid for under this plan;
(13) Expenses incurred for a core buildup will only be considered in conjunction with a crown;
(14) If multiple endodontic treatments are necessary on the same tooth within a period of one year, the allowance will be made for only one procedure;
(15) X-rays are considered an integral part of the endodontic procedure rather than a separate service and are therefore not eligible for benefits;
(16) The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions;
(17) Expenses for gross debridement allowed one time at the beginning of the periodontal treatment plan prior to pocket depth charting;
(18) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(19) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are a Covered Dental Expense on this Plan;
(20) Surgical procedures incidental to orthodontic treatment, including but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate;
(21) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(22) Expenses incurred for congenital or developmental malformations;
(23) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(24) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits;
(25) Chemotherapeutic agents and any other experimental procedures;
(26) Charges in excess of Usual, Reasonable and Customary charges or in excess of the Calendar Year Maximum amount stated in the “Schedule of Dental Benefits” section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(27) Expenses that are applied toward satisfaction of a Deductible, if any;
(28) Services and supplies performed outside of the United States of America;
(29) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, Your lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
(30) Expenses for services for which You would not legally have to pay if there were no insurance;
(31) Services not completed on or before the date of termination;
(32) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(33) Any service or procedure not commonly found within the scope of practice by a licensed dentist. Such procedures are identified within the current Common Dental Terminology (CDT Codes) published by the American Dental Association;
(34) Expenses incurred for services covered on a pediatric only dental plan.

PART 5 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Annual Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the

Deductible amount shown on the Schedule of Benefits.

Annual Maximum: The maximum amount BEST Life will reimburse for covered services during a twelve (12) month period for each Insured person. Once the full Annual Maximum amount has been paid, no additional services will be reimbursed for the remainder of that year. The

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Dependent: Means:
(1) Your lawful spouse or domestic partner and
(2) Your or Your spouse's or domestic partner's child or children, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted, from the date of placement, or any child for whom You have been granted legal custody, provided they are [less than][between 20 and] 26 years of age; or
(3) A child named in a Qualified Medical Child Support Order will be considered a dependent.

"Eligible Dependent" also means a dependent child, who upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, the child will continue to qualify as a dependent under this plan, provided You and the dependent child continue to be insured under this plan, and the child continues to be handicapped and dependent upon You for support. This shall not apply to a dependent child who is beyond the termination age on the date You become eligible for dependent insurance under this Policy.

Eligible Employee: Means:
(1) A full-time permanent employee who is:
  (a) permanently employed, working at least thirty (30) hours per week and paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and
  (b) not covered by a collective bargaining agreement which requires Your Participating Employer to make contributions; or
(2) A partner or proprietor actively engaged in the business on a full-time basis.

"Eligible Employee" does not mean an independent contractor, commission salesperson, consultant or a person who is in any manner self-employed.

Family Deductible: The Family Deductible is satisfied when each of three (3) covered members of Your family satisfy the Annual Deductible. Once the combined costs of services provided by covered members of Your family is equal to the Family Deductible amount, no additional Deductible will be required for other insured family members for the remainder of the Calendar Year.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Grace Period: A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

Insured: The Subscriber or any Eligible Dependent of a Subscriber who is enrolled in and covered under the Group Policy.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Subscriber:

(1) A full-time permanent employee who is permanently employed, working at least thirty (30) hours per week, paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and not covered by a collective bargaining agreement; or

(2) A partner or proprietor in a Subscribing Employer who is actively engaged in the business on a full-time basis.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Subscriber.

PART 6 - COVERAGE EFFECTIVE AND TERMINATION DATES

EFFECTIVE DATE

Employee: If You fill out and sign an enrollment card furnished by Us, Your insurance will take effect

on the later of:
(1) the date Your employer becomes a Participating Employer, if Your enrollment card is received by Us within thirty-one (31) days of that date; or
(2) the first day of the next calendar month following the date You complete one calendar month of active full-time employment for a Participating Employer. Your enrollment card must be received by Us within thirty-one (31) days after You satisfy the waiting period[; or
(3) the date You become a qualified employee.]

If Your enrollment card is received by Us more than thirty-one (31) days after You become eligible, You will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If You are not working full-time on the date Your coverage would otherwise take effect, You will not be covered until You return to active full-time employment.

Dependent: Your Dependent's insurance will take effect on the later of:
(1) the effective date of Your coverage, if You enrolled Your Dependent at the same time You applied for coverage; or
(2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within thirty-one (31) days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than thirty-one (31) days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

TERMINATION OF INSURANCE

The Insured’s coverage will stop on the earliest of the following dates:

(1) the last day of the month in which the Subscriber ceases active employment with the Participating Employer, unless Subscriber is on leave of absence, temporary layoff or total disability. In that case, Subscriber's Participating Employer may continue Insured's coverage by paying the required premium, but not beyond the following limits:
   (a) approved leave of absence, 3 months;
   (b) temporary layoff, the end of the month following the month, in which Subscriber's layoff started; or
   (c) total disability, 3 months;
(2) the last day of the month in which Subscriber ceases to be in a class of Subscriber eligible for insurance;
(3) the date Insured ceases to be in a class eligible for insurance under this plan;
(4) the last day of the month in which Subscriber request Subscriber's coverage to be cancelled;
(5) the day before the due date of any premium that remains unpaid at the end of the grace period;
(6) the date the Group Policy terminates;
(7) the date the Subscriber's Employer ceases to be a Participating Employer;
(8) the date the number of the Participating Employer's Subscribers falls below 2;
(9) the last day of the month in which an Insured ceases to meet the definition of Eligible Dependent; or
(10) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

Dependent: Your dependent's insurance will stop on the earliest of the following dates:
(1) the date Your insurance terminates;
(2) the date You fail to make a contribution for dependent insurance;
(3) the date You cease to be in a class eligible for dependent insurance; or
(4) the last day of the month in which a dependent ceases to meet the definition of "Dependent."

If a dependent child, upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and You notify Us in writing within thirty-one (31) days after the termination age, We will continue coverage as long as Your coverage continues and the child continues to be handicapped and dependent upon You for support.

PART 7 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary.

This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:

- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the Policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 8 –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal

premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Group Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the Grace Period.

Termination of Group Policy: We may terminate this Group Policy at any time following the first renewal date by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of reinstatement. The reinstated Policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 9 – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or

(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The Policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the Policy.

Right to Contest: After this Policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the Policy) commencing after two (2) years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
    (1) the due date to pay any required premium (if premium is not paid by that date).
    (2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
    (3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
    (4) a date which is:
        1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
        2. 36 months from the date coverage would have terminated, if coverage is

continued for any other reason.

PART 10 – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

PART 11 - SUMMARY PLAN DESCRIPTION SUPPLEMENT

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA), and together with the rest of your Certificate, it forms the Summary Plan Description.

(1) NAME OF PLAN: [Beneficial Employees Security Trust], [P.O. Box 3100, Newport Beach, California 92658-9027].
(2) PLAN IDENTIFICATION NUMBER: [501].
(3) TYPE OF ADMINISTRATION AND TYPE OF WELFARE PLAN: The plan is administered by [BEST Life and Health Insurance Company] located at [2505 McCabe Way, Irvine, California 92614], [(800) 433-0088]. Benefits are insured in accordance with the Group Dental Insurance Policy issued by BEST Life.
(4) AGENT FOR SERVICE: The Chief Legal counsel of BEST Life at [the above address].
(5) TRUSTEE OF THE PLAN: [Wells Fargo Bank, N.A., 180 South Main Street, 2nd Floor, Salt Lake City, Utah 84101].
(6) SOURCE OF PLAN CONTRIBUTION: The contributions necessary to finance the plan are made by the employer and employees.

(7) DATE OF END OF THE PLAN'S FISCAL YEAR: [December 31].

PART 12 - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a request for materials from the Plan and does not receive them within thirty (30) days, one may file suit in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

Underwritten by BEST Life and Health Insurance Company

VARIABILITY STATEMENT

GAD-PPO-POL-0113TN

Title Page – The address and officers of the company may change; Policy.

Page 2 – The President and Secretary of the company may change.

Page 3 – Specific to the Client.

Policyholder – Is the trustee of the Beneficial Employees Security Trust of Utah. Is bracketed in case the name of the trust changes.

Schedule of Benefits – we are offering four plan designs. We have provided the full range of possibilities that would apply. In the final Certificate, only the plan that was selected will appear.

Major Dentistry Waiting Period Waiver – Our plans with a 12-month wait for Major Services may have the waiting period waived based on prior coverage. This section is bracketed and will only appear for plans with a 12-month wait. Plans without a 12-month wait will not have this information in their Certificate.

Part 2 Benefits – We may offer a 12-month wait on Major and Orthodontic Services. A statement disclosing this is bracketed. Plans without a 12-month wait will not have this in their certificate. Orthodontic benefits are bracketed since this is an optional benefit only. Plans that do not have Orthodontia will not have this information provided in their Certificate.

CLASS IV – Orthodontic Procedures – will only appear on plans that include coverage for child Orthodontia. Payment may be offered at 1/3 or 1/2 of the Lifetime Maximum Benefit. Only one of these will be chosen at the time we implement these plans. It is bracketed in case we want to change this benefit for new contracts at a later time.

Definitions -- Eligible Dependent (2), the limiting age is bracketed so that employers with pediatric benefits embedded in their medical plan have the option of defining eligible children as those between 20 and 26 years of age.

Effective Date for the Employee - Item #3 is bracketed and will be specific to the Client. The Client may not want coverage effective on the date the employee qualifies.

General Provisions

- **Notice of Claim** – Address may change.

Filing a Dental Claim

- How to file a claim – URLs and contact information are bracketed to allow for changes, and possibly a third party administrator. Right now, there is no contract with a third party administrator, so BEST Life's current contact information is provided.
- Appealing the denial of a claim – address may change.

Summary Plan Description Supplement – Bracketed information will be specific to the Policyholder, addresses may change.

GAD-PPO-CERT-0113TN

Title Page –The address of the company may change.

Page 2 – The President and Secretary of the company may change.

Statement of Coverage – Group and Insured information will be provided in the bracketed fields.

- **Subscriber Name –** Specific to individual purchasing the plan.
- **Certificate Effective Date –** Specific to the plan year for the Exchange.
- **Insured name(s) and Effective Dates(s) –** specific to client.
- **Participating employer name and number –** specific to the client.
- **Plan information** – We are transitioning to a new administrative system. Our current administrative system provides plan selection information in the Statement of Coverage. The new administrative system will provide this information in the Schedule of Benefits. The Plan, Deductible, and Annual Maximum is bracketed because these fields will no longer be provided once the new system is up and running.
- **Group Policy Number** – Specific to the client.

Policyholder – Is the trustee of the Beneficial Employees Security Trust of Utah. Is bracketed in case the name of the trust changes.

Schedule of Benefits – we are offering four plan designs. We have provided the full range of possibilities that would apply. In the final Certificate, only the plan that was selected will appear.

Major Dentistry Waiting Period Waiver – Our plans with a 12-month wait for Major Services may have the waiting period waived based on prior coverage. This section is bracketed and will only appear for plans with a 12-month wait. Plans without a 12-month wait will not have this information in their Certificate.

Part 2 Benefits – We may offer a 12-month wait on Major and Orthodontic Services. A statement disclosing this is bracketed. Plans without a 12-month wait will not have this in their certificate. Orthodontic benefits are bracketed since this is an optional benefit only. Plans that do not have Orthodontia will not have this information provided in their Certificate.

CLASS IV – Orthodontic Procedures – will only appear on plans that include coverage for child Orthodontia. Payment may be offered at 1/3 or 1/2 of the Lifetime Maximum Benefit. Only one of these will be chosen at the time we implement these plans. It is bracketed in case we want to change this benefit for new contracts at a later time.

Definitions – Eligible Dependent (2), the limiting age is bracketed so that employers with pediatric benefits embedded in their medical plan have the option of defining eligible children as those between 20 and 26 years of age.

Effective Date for the Employee - Item #3 is bracketed and will be specific to the Client. The Client may not want coverage effective on the date the employee qualifies.

General Provisions

- **Notice of Claim** – Address may change.

Filing a Dental Claim

- How to file a claim – URLs and contact information are bracketed to allow for changes, and possibly a third party administrator. Right now, there is no contract with a third party administrator, so BEST Life's current contact information is

provided.

- Appealing the denial of a claim – address may change.

Summary Plan Description Supplement – Bracketed information will be specific to the Policyholder, addresses may change.

GAD-PPO-EAP-0113TN

Title of Application – plan name is bracketed.

Dental Plan Selection – the plan names are bracketed since the name may change. We are providing the full range of benefits possible within the brackets for each benefit level.

Waiting Period Waiver – We currently offer waiting period waivers for groups based on group size and if they have prior coverage. We would like to offer the same waiting period waivers if we provide waiting periods on major and orthodontic services on our Supplemental (Adult Only) plans. This section will be taken out if no waiting periods are offered on the Supplemental (Adult Only) dental plans.

Group Insurance Policy

Dental PPO Pediatric Plan

[2505 McCabe Way
Irvine, California 92614]

Notice to Buyer: This Policy provides dental coverage for children only.

GPD-PPO-POL-0113TN

BEST Life and Health Insurance Company
[2505 McCabe Way
Irvine, California 92614]

A STOCK COMPANY
(Herein called the Company)

BEST Life and Health Insurance Company, in consideration of the application of the Subscribing Employer and the payment of premiums as due, agrees, subject to the terms and conditions of this Group Policy, to insure Eligible Employees of Subscribing Employers to the Group Policyholder and their eligible Dependents under this Group Policy.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Utah. Its terms are governed by and shall be construed in accordance with the laws of the Governing Jurisdiction.

This Group Policy becomes effective at 12:01 a.m., Standard Time at the office of the Group Policyholder on the Group Policy Effective Date in the State of Delivery specified below. Subject to the terms and conditions of this Group Policy, it can be renewed until the First Renewal Date by timely payment of the required premium by the Group Policyholder. Unless terminated in accordance with the applicable provision of this Group Policy, it can be renewed after such time from month to month, subject to the terms and conditions of this Group Policy, by timely payment of the required premium.

NOTICE OF TEN DAY RIGHT TO EXAMINE: We want You to fully understand and be satisfied with the insurance coverage. If for any reason You are not satisfied, You may return this Group Policy to the agent or to Our home office within ten days of receipt and the premium will be fully refunded. Coverage will then be void retroactive to the Insurance Effective Date.

This Group Policy may be modified by mutual agreement between the Group Policyholder and Us.

The provisions and the terms in the Certificate are part of this Group Policy. A copy of the Certificate is attached to, and made a part of this Group Policy.

Signed for **BEST Life and Health Insurance Company** by its President and Secretary at [2505 McCabe Way, Irvine, California 92614.]

[ ][

President Secretary

Group PPO
Pediatric Dental Policy
Non-Participating

Group Policyholder: Beneficial Employees Security Trust of Utah

Group Policy Effective Date: [XX-XX-XXXX]

Group Policy Number: [XXX]

State of Delivery: Utah

Premiums Due On: 1st of each month

First Renewal Date: [XX-XX-XXXX]

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PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [The Trustee of the Beneficial Employees Security Trust of Utah]

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the 80th percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

[

	PPO High Pediatric Dental Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible – Applies to Basic and Major services received In-Network or Out-of-Network	$0	$50
Diagnostic & Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	90%
Basic Services Coinsurance – Fillings	70%	60%
Major Services Coinsurance – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	50%	40%
Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)	50%	50%

]

[

	PPO Low Pediatric Dental Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible – Applies to Preventive, Basic and Major services received In-Network or Out-of-Network	$50	$100
Diagnostic & Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	60%
Basic Services Coinsurance – Fillings	55%	40%
Major Services Coinsurance – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	35%	20%
Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)	50%	50%

]

PART 2 - BENEFITS

Covered Services

Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

Class I – Preventive and Diagnostic Procedures Include:

(1) Prophylaxis not more often than once every 6 months;
(2) Topical application of fluoride (excluding prophylaxis) not more often than twice every 12 months;
(3) Topical fluoride varnish not more often than twice every 12 months;
(4) Sealants not more often than once per tooth in a 36-month period and limited to unrestored permanent molars for individuals under age 19;
(5) Space maintainers, including re-cementation, for individuals under age 19 (excluding removal of fixed space maintainer);
(6) Periodic oral evaluation not more often than once every 6 months;
(7) Limited oral evaluation (problem focused) not more often than once every 6 months;
(8) Comprehensive oral evaluation not more often than once every 6 months;
(9) Comprehensive periodontal evaluation not more often than once every 6 months;
(10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
(11) Bitewing X-rays not more often than one set every 6 months;

(12) Single film intraoral periapical or occlusal;
(13) Palliative treatment of dental pain (minor procedure);

Class II – Basic Procedures Include:

(1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
(2) Prefabricated stainless steel crowns not more often than once per tooth in a 60-month period for individuals under age 15;
(3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within 45 days of the pulpotomy;
(4) Partial pulpotomy for apexogensis limited to permanent tooth with incomplete root development, if a root canal is not performed within 45 days of pulpotomy;
(5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age 6, and limited to primary molars and cuspids for individuals up to age 11;
(6) Periodontal scaling and root planning, per quadrant, not more often than once every 24 months;
(7) Periodontal maintenance not more often than four in a 12-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
(8) Adjustment and repair of complete or partial dentures;
(9) Rebase and reline not more often than once in a 36-month period, 6 months after initial installation;
(10) Tissue conditioning;
(11) Recement fixed partial denture
(12) Fixed partial denture repair, by report;
(13) Oral surgery:
    a. extraction for erupted tooth or exposed root;
    b. surgical removal of erupted tooth;
    c. removal of impacted tooth;
    d. removal of residual tooth roots;
    e. coronectomy;
    f. tooth reimplantation;
    g. surgical access of unerupted tooth;
    h. alveoloplasty;
    i. removal of exostosis;
    j. incision and drainage of abscess;
    k. suture of recent small wounds up to 5 cm
    l. excision of pericoronal gingival;

Class III – Major Procedures Include:

(1) Detailed and extensive oral evaluation;
(2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every 60 months;
(3) Endodontics (rooth canal)
(4) Gingivectomy or gingivoplasty, four or more teeth not more often than once every 36 months;
(5) Gingival flap procedure, four or more teeth not more often than once every 36 months;
(6) Osseous surgery, four or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every 36 months;
(7) Full mouth debridement limited to one per lifetime;
(8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every 60 months (excludes interim dentures);

(9) Implants and implant services once every 60 months only if medically necessary;
(10) Occlusal guard not more often than once in 12 months for individuals 13 and older with predetermination only;
(11) General anesthesia or IV sedation;
(12) Consultation by dentist or physician other than the dentist providing treatment;
(13) Therapeutic drug injection with predetermination;
(14) Treatment of post-surgical complications with predetermination.

Class IV – Orthodontic Procedures Include:
(1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
(2) Requires predetermination; and
(3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:
BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:
(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
(2) Emergency treatment; or
(3) Oral examination and prophylaxis.

Predetermination is required for the following dental services:
(1) Medically necessary service or supplies;

(2) Crowns (other than stainless steel);
(3) Apicoectomy;
(4) Non-emergency third molar extractions;
(5) Maxillofacial prosthetics;
(6) Orthodontia;
(7) Emergency room services provided by a dentist; and
(8) Inpatient hospital services.

We will have 30 days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

PART 4 – EXCLUSIONS

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Space maintainers;
(8) Sealants if re-sealed within a 5-year period;
(9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
(10) Elective tooth extractions;
(11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;

(12) Expenses incurred for gingivectomy or gingivoplasty, periodontal scaling and root planning, full mouth debridement, and periodontal maintenance;
(13) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
(14) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(15) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(16) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
(17) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
(18) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(19) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
(20) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
(21) Services not completed on or before the date of termination;
(22) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(23) Expenses that are applied toward satisfaction of a Deductible, if any;
(24) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
(25) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(26) Chemotherapeutic agents and any other experimental procedures;
(27) Expenses incurred for veneers and related procedures;
(28) Services and supplies performed outside of the United States of America.

PART 5 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Out-of-Pocket Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Child: A person who is less than 20 years of age on the effective date of the person's coverage.

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Dependent: A Child, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted from the date of placement, any child for whom the Subscriber has been granted legal custody, or a Child named in a Qualified Medical Child Support Order or other court or administrative order.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Grace Period: A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

Insured: Any Eligible Dependent of a Subscriber who is enrolled in and covered under the Group Policy.

Medically Necessary: The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Out-of-Pocket Maximum: The total amount of expenses related to Covered Services, in addition to the Deductible, that must be paid on behalf of an Insured on an Annual basis.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental care or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into

consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Subscriber:

(1) A full-time permanent employee who is permanently employed, working at least thirty (30) hours per week, paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and not covered by a collective bargaining agreement; or

(2) A partner or proprietor in a Subscribing Employer who is actively engaged in the business on a full-time basis.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Insured.

PART 6 - COVERAGE EFFECTIVE AND TERMINATION DATES

EFFECTIVE DATE

Dependent: Your Dependent's insurance will take effect on the later of:

(1) the effective date of Your coverage, if You enrolled Your Dependent at the same time You applied for coverage; or

(2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within 31 days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than 31 days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

TERMINATION OF INSURANCE

The Insured’s coverage will stop on the earliest of the following dates:

(1) the last day of the month in which the Subscriber ceases active employment with the Participating Employer, unless Subscriber is on leave of absence, temporary layoff or total disability. In that case, Subscriber's Participating Employer may continue Insured's coverage by paying the required premium, but not beyond the following limits:
   (a) approved leave of absence, 3 months;
   (b) temporary layoff, the end of the month following the month, in which Subscriber's layoff started; or
   (c) total disability, 3 months;
(2) the last day of the month in which Subscriber ceases to be in a class of Subscriber eligible for insurance;
(3) the date Insured ceases to be in a class eligible for insurance under this plan;
(4) the last day of the month in which Subscriber request Subscriber's coverage to be cancelled;
(5) the day before the due date of any premium that remains unpaid at the end of the grace period;
(6) the date the Group Policy terminates;
(7) the date the Subscriber's employer ceases to be a Participating Employer;
(8) the date the number of the Participating Employer's Subscribers falls below 2;
(9) the last day of the month in which an Insured ceases to meet the definition of Eligible Dependent; or
(10) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

PART 7 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured you is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:
- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of

the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 8 –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Group Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the Grace Period.

Termination of Group Policy: We may terminate this Group Policy at any time following the first renewal date by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of

reinstatement. The reinstated policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 9 – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or

(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the policy.

Right to Contest: After this policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the policy) commencing after two (2) years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and

Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
    (1) the due date to pay any required premium (if premium is not paid by that date).
    (2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
    (3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
    (4) a date which is:
        1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
        2. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

PART 10 – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

PART 11 - SUMMARY PLAN DESCRIPTION SUPPLEMENT

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA), and together with the rest of your Certificate, it forms the Summary Plan Description.

(1) NAME OF PLAN: [Beneficial Employees Security Trust], [P.O. Box 3100, Newport Beach, California 92658-9027].
(2) PLAN IDENTIFICATION NUMBER: [501].
(3) TYPE OF ADMINISTRATION AND TYPE OF WELFARE PLAN: The plan is administered by [BEST Life and Health Insurance Company] located at [2505 McCabe Way, Irvine, California 92614], [(800) 433-0088]. Benefits are insured in accordance with the Group Dental Insurance Policy issued by BEST Life.
(4) AGENT FOR SERVICE: The Chief Legal counsel of BEST Life at [the above address].
(5) TRUSTEE OF THE PLAN: [Wells Fargo Bank, N.A., 180 South Main Street, 2nd Floor, Salt Lake City, Utah 84101].
(6) SOURCE OF PLAN CONTRIBUTION: The contributions necessary to finance the plan are made by the employer and employees.
(7) DATE OF END OF THE PLAN'S FISCAL YEAR: [December 31].

PART 12 - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a request for materials from the Plan and does not receive them within 30 days, one may file suit in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

Group Insurance Policy

Dental PPO Pediatric Plan

[2505 McCabe Way
Irvine, California 92614]

Notice to Buyer: This Certificate provides dental coverage for children only.

GPD-PPO-CERT-0113TN

CERTIFICATE OF GROUP INSURANCE

Issued By

BEST Life and Health Insurance Company

A STOCK COMPANY
(Herein called the "We," "Us," "Company" or "BEST Life")

BEST Life and Health Insurance Company certifies that Insureds are covered for the benefits described in this Certificate, subject to the limitations and exclusions of this Certificate and of the Group Policy. The Group Policy is the contract between BEST Life and the Policyholder named on the Schedule of Benefits. The Group Policy may be changed or ended without the consent of or notice to the Certificate holder.

This Certificate replaces any certificate previously issued by BEST Life.

PLAN EFFECTIVE DATE: Insurance is in effect on the date shown on the Certificate Statement of Coverage.

GOVERNING JURISDICTION: The Group Policy is issued in the State of Utah. It shall be construed in accordance with the laws of the issuing State.

BEST Life and Health Insurance Company's President and Secretary signed this at [2505 McCabe Way, Irvine, California 92614].

[ ] [ ]

President **Secretary**

GROUP PPO PEDIATRIC
DENTAL NON-PARTICIPATING

THIS INSURANCE DOES NOT COVER INJURIES OR ILLNESSES THAT HAPPEN IN THE COURSE AND SCOPE OF EMPLOYMENT. ASK YOUR PARTICIPATING EMPLOYER WHETHER YOU ARE PART OF A WORKERS' COMPENSATION SYSTEM.

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This Certificate Is Not Valid
Unless There Is a Complete Statement of Coverage

Statement of Coverage

PEDIATRIC DENTAL

INSURANCE SUBSCRIBER NAME: [JOHN D. DOE]
CERTIFICATE EFFECTIVE DATE: [01/01/2014]

INSURED NAME(S) AND EFFECTIVE DATE(S):
[JANE DOE 01/01/2014]
[JON DOE 01/01/2014]

PARTICIPATING EMPLOYER NAME: [CUSTOMER NAME]
PARTICIPATING EMPLOYER NUMBER: [OR00XXX0000XX]

[**PLAN:** [PPO HIGH]
DEDUCTIBLE: [$50]
OUT OF POCKET MAXIMUM: [$700]]

GROUP POLICY NO.: [XXXXXXXXX]]

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PART 1 - SCHEDULE OF BENEFITS

This Certificate of Group Coverage is made valid on the effective dates shown for the listed Insureds on the Statement of Coverage.

The Policy is issued by BEST Life and Health Insurance Company to: [The Trustee of the Beneficial Employees Security Trust of Utah]

Covered Services received by Insured from a Network Provider are reimbursed at the Network Provider's contracted Fee Schedule. Covered Services received by Insured from an Out-of-Network Provider are reimbursed at the 80th percentile of a Usual, Reasonable and Customary schedule. All Covered Services are subject to Cost Sharing as shown on this Schedule of Benefits.

[

	PPO High Pediatric Dental Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible – Applies to Basic and Major services received In-Network or Out-of-Network	$0	$50
Diagnostic & Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	90%
Basic Services Coinsurance – Fillings	70%	60%
Major Services Coinsurance – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	50%	40%
Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)	50%	50%

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	PPO Low Pediatric Dental Plan	
Procedure Categories	**In-Network [Network Name]**	**Out-of-Network**
Out-of-Pocket Maximum	$700 for 1 Child $1,400 for 2 or more Children	$700 for 1 Child $1,400 for 2 or more Children
Annual Deductible – Applies to Preventive, Basic and Major services received In-Network or Out-of-Network	$50	$100
Diagnostic & Preventive Services Coinsurance – Exams, cleanings, sealants, fluoride treatment, x-rays	100%	60%
Basic Services Coinsurance – Fillings	55%	40%
Major Services Coinsurance – Crowns & casts, prosthodontics, endodontics, periodontics, oral surgery	35%	20%
Orthodontic Services Coinsurance (Medically necessary Orthodontic Services only)	50%	50%

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PART 2 - BENEFITS

Covered Services
Covered Services are those services described below, unless they are limited or excluded elsewhere in this Certificate.

Class I – Preventive and Diagnostic Procedures Include:

(1) Prophylaxis not more often than once every 6 months;
(2) Topical application of fluoride (excluding prophylaxis) not more often than twice every 12 months;
(3) Topical fluoride varnish not more often than twice every 12 months;
(4) Sealants not more often than once per tooth in a 36-month period and limited to unrestored permanent molars for individuals under age 19;
(5) Space maintainers, including re-cementation, for individuals under age 19 (excluding removal of fixed space maintainer);
(6) Periodic oral evaluation not more often than once every 6 months;
(7) Limited oral evaluation (problem focused) not more often than once every 6 months;
(8) Comprehensive oral evaluation not more often than once every 6 months;
(9) Comprehensive periodontal evaluation not more often than once every 6 months;
(10) Intraoral complete X-rays or panoramic film not more often than once in a 60-month period;
(11) Bitewing X-rays not more often than one set every 6 months;

(12) Single film intraoral periapical or occlusal;
(13) Palliative treatment of dental pain (minor procedure);

Class II – Basic Procedures Include:

(1) Amalgams, resin-based composites, re-cement inlays, re-cement crowns, protective restoration, pin retention;
(2) Prefabricated stainless steel crowns not more often than once per tooth in a 60-month period for individuals under age 15;
(3) Therapeutic pulpotomy (excluding restoration) if a root canal is not performed within 45 days of the pulpotomy;
(4) Partial pulpotomy for apexogensis limited to permanent tooth with incomplete root development, if a root canal is not performed within 45 days of pulpotomy;
(5) Pulpal therapy (excluding final restoration) once per tooth per lifetime, limited to primary incisor teeth for individuals up to age 6, and limited to primary molars and cuspids for individuals up to age 11;
(6) Periodontal scaling and root planning, per quadrant, not more often than once every 24 months;
(7) Periodontal maintenance not more often than four in a 12-month period, combined with adult prophylaxis after the completion of active periodontal therapy;
(8) Adjustment and repair of complete or partial dentures;
(9) Rebase and reline not more often than once in a 36-month period, 6 months after initial installation;
(10) Tissue conditioning;
(11) Recement fixed partial denture
(12) Fixed partial denture repair, by report;
(13) Oral surgery:
    a. extraction for erupted tooth or exposed root;
    b. surgical removal of erupted tooth;
    c. removal of impacted tooth;
    d. removal of residual tooth roots;
    e. coronectomy;
    f. tooth reimplantation;
    g. surgical access of unerupted tooth;
    h. alveoloplasty;
    i. removal of exostosis;
    j. incision and drainage of abscess;
    k. suture of recent small wounds up to 5 cm
    l. excision of pericoronal gingival;

Class III – Major Procedures Include:

(1) Detailed and extensive oral evaluation;
(2) Inlays, onlays, crowns, core buildup, including any pins, prefabricated post and core in addition to crown, limited to one per tooth every 60 months;
(3) Endodontics (rooth canal)
(4) Gingivectomy or gingivoplasty, four or more teeth not more often than once every 36 months;
(5) Gingival flap procedure, four or more teeth not more often than once every 36 months;
(6) Osseous surgery, four or more contiguous teeth or bounded teeth spaces per quadrant, not more often than once every 36 months;
(7) Full mouth debridement limited to one per lifetime;
(8) Complete and partial dentures, including abutments, pontics, onlays, retainers and crowns, not more often than once every 60 months (excludes interim dentures);

(9) Implants and implant services once every 60 months only if medically necessary;
(10) Occlusal guard not more often than once in 12 months for individuals 13 and older with predetermination only;
(11) General anesthesia or IV sedation;
(12) Consultation by dentist or physician other than the dentist providing treatment;
(13) Therapeutic drug injection with predetermination;
(14) Treatment of post-surgical complications with predetermination.

Class IV – Orthodontic Procedures Include:
(1) For orthodontia services associated with the repair of cleft palate and palate or other severe craniofacial defects or injury for which the function of speech, swallowing or chewing is restored;
(2) Requires predetermination; and
(3) Coverage includes diagnosis, treatment plan, anticipated treatment time and cost estimate.

PART 3 - LIMITATIONS AND COST SHARING

ACCESS TO CARE

Using a Network Provider:
BEST Life offers Insureds the option to save on out-of-pocket costs when care is provided by a Network Provider. A listing of General Dentists and Specialists is available. To find a Network Provider, please refer to the Network information provided on the ID Card.

How to Select a Dentist:
Insureds on this Plan may obtain dental services from any licensed dental professional in the United States. To use the Plan, Insureds may directly contact the dentist of their choice and make an appointment. Insureds are advised to bring their ID Card to their appointment. The dentist may require a copy of the Insured's ID Card to confirm eligibility on this Plan.

How to Obtain a Referral:
A dentist may determine that an Insured requires treatment from a dental provider that specializes in a type of dentistry (Specialist). The Insured does not need to contact BEST Life for a referral. The Insured can directly contact the Specialist to make an appointment. The Specialist may require information from the Insured's dentist to determine a treatment plan and may contact the dentist directly.

ADVANCE NOTICE OF DENTAL TREATMENT

Subscriber or Insured should submit Advance Notice of Dental Treatment before treatment commences in order to obtain Predetermination of Covered Services, including services that are medically necessary. If dental services are performed without such Predetermination, We reserve the right to deny any claim submitted with respect to such Covered Services; provided however, that predetermination is not required for:
(1) Covered Services for which the related expense is less than $500 during any course of treatment ("course of treatment" means one treatment or one of a planned series of treatments resulting from dental examination);
(2) Emergency treatment; or
(3) Oral examination and prophylaxis.

Predetermination is required for the following dental services:
(1) Medically necessary service or supplies;

(2) Crowns (other than stainless steel);
(3) Apicoectomy;
(4) Non-emergency third molar extractions;
(5) Maxillofacial prosthetics;
(6) Orthodontia;
(7) Emergency room services provided by a dentist; and
(8) Inpatient hospital services.

We will have 30 days to furnish the provider with an Explanation of Benefits demonstrating whether the proposed treatment will be a Covered Service under this Group Policy.

DEDUCTIBLES

Annual Deductible: The Annual Deductible shown in the Schedule of Dental Benefits will apply separately to each Insured. Each Insured must accumulate eligible expenses equal to the deductible amount.

ALTERNATIVE PROCEDURES

If more than one treatment plan exists for a dental procedure, covered dental expenses will be based on the least expensive procedure that will produce a result that meets professionally recognized standards. If the Insured's provider elects the more expensive treatment, the Insured or Subscriber shall be responsible for any charges that are greater than the covered expense for the less expensive treatment.

PART 4 – EXCLUSIONS

The following exclusions are not Covered Services. No payments will be made by Us for these services:

(1) Treatment by someone other than a doctor of medical dentistry or a doctor of dental surgery, except where performed by a licensed hygienist under the direction of a doctor of medical dentistry or a doctor of dental surgery, or a denturist;
(2) Expenses incurred while on active duty with any military, naval, or air force of any country or international organization;
(3) Expenses incurred as a result of participating in a riot or insurrection or the commission of a felony;
(4) Services and supplies covered under any Worker's Compensation Act or similar law; expenses incurred due to treatment rendered by Your employer;
(5) Services and supplies started and not completed before the patient was covered under this Plan, including but not limited to: an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or other lab fabricated restorations for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
(6) Dental services and supplies which are given primarily for cosmetic reasons including alteration or extraction of functional natural teeth for the purpose of changing appearance and replacement of restorations previously performed for cosmetic reasons;
(7) Space maintainers;
(8) Sealants if re-sealed within a 5-year period;
(9) Retreatment of a previous root canal or apicoectomy/periradicular surgery;
(10) Elective tooth extractions;
(11) Separate payments for open and drain palliative procedure when the root canal is completed on the same date of service;

(12) Expenses incurred for gingivectomy or gingivoplasty, periodontal scaling and root planning, full mouth debridement, and periodontal maintenance;
(13) Expenses incurred for orthodontic treatment and orthodontia type procedures unless such procedures are defined as a Covered Dental Expense;
(14) Charges in excess of Usual, Reasonable and Customary charges amount stated in the "Schedule of Benefits" section of this Plan, or in excess of the Preferred Provider Fee Schedule;
(15) Charges for service provided for temporomandibular joint dysfunction (TMJ);
(16) Expenses incurred for congenital or developmental malformations, except as defined as a Covered Orthodontic Expense;
(17) Any services or supplies for correction or alteration of occlusion, or any occlusal adjustments; expenses incurred for night guards or any other appliances for the correction of harmful habits, except as defined as a Covered Orthodontic Expense;
(18) Expenses for "safe fees" (gloves, masks, surgical scrubs and sterilization);
(19) Expenses incurred due to treatment rendered by a family member. For the purpose of this limitation, "family member" includes, but is not limited to, the patient's lawful spouse, domestic partner, child, child of Your domestic partner, parent, step-parent, grandparent, brother, sister, cousin or in-law;
(20) Expenses for services for which the patient would not legally have to pay if there were no insurance, unless mandated by the State;
(21) Services not completed on or before the date of termination;
(22) If an Insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, BEST Life shall be liable only for the amount it would have been liable for had one dentist rendered the services;
(23) Expenses that are applied toward satisfaction of a Deductible, if any;
(24) Any service or procedure not commonly found within the scope of practice by a licensed dentist;
(25) Temporary services are considered an integral part of the final services rather than a separate service and are therefore not eligible for benefits;
(26) Chemotherapeutic agents and any other experimental procedures;
(27) Expenses incurred for veneers and related procedures;
(28) Services and supplies performed outside of the United States of America.

PART 5 - DEFINITIONS

Annual: The twelve (12) month period beginning on the effective date of the Certificate and ending on the termination date of the Certificate. The Annual time frame will be applied to the Deductible and the Out-of-Pocket Maximum amount.

Annual Deductible: The amount each Insured must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, the Insured must accumulate expenses for Covered Services equal to the Deductible amount shown on the Schedule of Benefits.

Certificate Effective Date: The date shown on the Statement of Coverage as the Certificate Effective Date.

Child: A person who is less than 20 years of age on the effective date of the person's coverage.

Coinsurance: The amount of an expense for a Covered Service that we will pay once the deductible is satisfied.

Covered Service: A service or supply listed as a Covered Service and not otherwise limited or excluded by this Certificate. A Covered Service must be provided by a doctor of medical dentistry or a doctor of dental surgery, or a denturist.

Eligible Dependent: A Child, including a natural child, step-child, foster child, lawfully adopted child or child in the process of being adopted from the date of placement, any child for whom the Subscriber has been granted legal custody, or a Child named in a Qualified Medical Child Support Order or other court or administrative order.

Emergency Care: A dental emergency where an acute disorder of oral health requires dental and/or medical attention, including broken, loose, or evulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Grace Period: A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each premium after the first. This coverage will remain in effect during the Grace Period; provided the premium is paid before the end of the Grace Period.

Insured: Any Eligible Dependent of a Subscriber who is enrolled in and covered under the Group Policy.

Medically Necessary: The determination process that may include, and not limited to, the evaluation of the effectiveness and benefit of a dental service or supply for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including interventions, and the cost effectiveness of such service or supply. Medical necessity may be obtained by applying an Advance Notice of Treatment.

Network Provider: A dental care professional that is contracted with Us and is part of the Network shown on the Schedule of Benefits.

Out-of-Network Provider: A dental care professional that is not a Network Provider.

Out-of-Pocket Maximum: The total amount of expenses related to Covered Services, in addition to the Deductible, that must be paid on behalf of an Insured on an Annual basis.

Participating Employer: An employer who meets all the eligibility, participation and enrollment requirements established under the Group Policy, and who subscribes to the Group Policy for the benefit of its employees.

Plan: Means any Plan providing benefits or services for or by reason of dental care or treatment, which benefits or services are provided in: (1) group, blanket or franchise insurance coverage; (2) group practice and other group prepayment coverage; (3) group service Plans; (4) any coverage under labor management trustee Plans, union welfare Plans, Employer organization Plans or Employee benefit organization Plans; and (5) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan" shall not include any plan of individual coverage or school or church accident type coverages.

The term "Plan" shall be construed separately with respect to each Policy, contract or other arrangement for benefits or services and separately with respect to that portion of such Policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into

consideration in determining its benefits and that portion which does not.

Statement of Coverage: The proof of insurance issued to an individual insured under the Group Policy, outlining the insurance benefits and principle provisions applicable to the member.

Subscriber:

(1) A full-time permanent employee who is permanently employed, working at least thirty (30) hours per week, paid a salary, wages, or earnings from which federal and state tax and Social Security deductions are made; and not covered by a collective bargaining agreement; or

(2) A partner or proprietor in a Subscribing Employer who is actively engaged in the business on a full-time basis.

Usual, Reasonable and Customary: The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

You or Your: Means the Insured.

PART 6 - COVERAGE EFFECTIVE AND TERMINATION DATES

EFFECTIVE DATE

Dependent: Your Dependent's insurance will take effect on the later of:

(1) the effective date of Your coverage, if You enrolled Your Dependent at the same time You applied for coverage; or

(2) the first day of the next calendar month following the date You enroll in writing for dependent insurance. Such enrollment must be within 31 days of the Dependent first becoming eligible.

If We receive Your Dependent enrollment card more than 31 days after a Dependent becomes eligible, Your Dependent will be considered a LATE ENTRANT. A "late entrant" shall only be eligible for Preventive Dental Procedures during the first 12 months of continuous coverage.

During the second 12 months of continuous coverage, a "late entrant" shall only be eligible for Preventive Dental Procedures and for 50% of the Benefits for Basic Dental Procedures. During this second 12 months of continuous coverage, the "late entrant" Benefits shall not exceed a maximum of $500.

The "late entrant" Benefits are subject to the Annual Deductible and Percentage Payable shown in the Schedule of Benefits of this Certificate, except as stated for Basic Dental Procedures above.

If a Dependent, other than a newborn dependent, is confined in a medical facility on the date his or her insurance would otherwise take effect, that Dependent will not be covered until the confinement ends.

Your dependent insurance will continue as long as Your Dependents remain eligible, contributions are made, and Your insurance remains in effect.

TERMINATION OF INSURANCE

The Insured's coverage will stop on the earliest of the following dates:

(1) the last day of the month in which the Subscriber ceases active employment with the Participating Employer, unless Subscriber is on leave of absence, temporary layoff or total disability. In that case, Subscriber's Participating Employer may continue Insured's coverage by paying the required premium, but not beyond the following limits:
   (a) approved leave of absence, 3 months;
   (b) temporary layoff, the end of the month following the month, in which Subscriber's layoff started; or
   (c) total disability, 3 months;
(2) the last day of the month in which Subscriber ceases to be in a class of Subscriber eligible for insurance;
(3) the date Insured ceases to be in a class eligible for insurance under this plan;
(4) the last day of the month in which Subscriber request Subscriber's coverage to be cancelled;
(5) the day before the due date of any premium that remains unpaid at the end of the grace period;
(6) the date the Group Policy terminates;
(7) the date the Subscriber's employer ceases to be a Participating Employer;
(8) the date the number of the Participating Employer's Subscribers falls below 2;
(9) the last day of the month in which an Insured ceases to meet the definition of Eligible Dependent; or
(10) the day the Insured moves outside of the service area for Insured's selected network. Insured may request a plan change if Insured moves within an area where an alternate plan is available.

BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of this insurance coverage.

PART 7 – COORDINATION OF BENEFITS

Benefits Subject to this Provision: All of the benefits provided under the Policy are subject to this provision.

If an Insured you is covered by two or more group health insurance policies, the policies may coordinate benefits. Group insurance was designed to cover dental expenses; however, it was never intended to pay in excess of 100% of incurred charges. Coordination of Benefits is established as a method by which two or more carriers or plans could coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

When there are two or more group carriers involved, one of the carriers is primary and one is secondary. This continues for all carriers involved. The primary carrier pays first, the secondary carrier pays second. This continues for all carriers involved. The order of the carriers is determined, as follows:

Dependent Children of Non-Separated or Divorced Parents: The plan covering the parent whose birthday falls earlier in the year is the primary carrier for an Insured under this Certificate. If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

Dependent Children of Separated or Divorced Parents: The plans must pay in the following order:
- First, the plan of the parent with custody of the child;
- Then, the plan of the spouse or domestic partner of the parent with custody of the child;
- Finally, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of

the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Dependent Children of Parents With Joint Custody: The birthday rule applies in this situation.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provisions of similar purpose of any other Plan, We may, with the consent of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which We deem to be necessary for such purposes. Such information may include information for payment of claims, information to administer your benefits or information to determine medical necessity with our case manager. Any person claiming benefits under this Plan shall furnish to Us such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with the Policy have been made under any other Plans, We shall have the right to pay over to any organizations making such other payments any amounts to satisfy our obligation under the policy, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, We shall be fully discharged from liability under this Plan.

Right to Recovery: Whenever payments have been made by Us with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, We shall have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments are made, any other insurers, service Plans or any other organizations.

PART 8 –PREMIUM PROVISIONS

Premium Payments: Renewal premiums are payable to the Company. The payment of any premium shall not continue this Group Policy in force beyond the next premium due date, except as provided in the Grace Period provision.

Changes in Premiums: We may change the amount of the required premium due from the Group Policyholder by giving the Group Policyholder at least sixty (60) days advance written notice. During the first 12 months, We will not change the amount of the required premium.

Grace Period: This Group Policy has a thirty-one (31) day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, this Group Policy will remain in force. If the required premium is not paid by the end of this Grace Period, this Group Policy will lapse as of the end of the Grace Period.

Termination of Group Policy: We may terminate this Group Policy at any time following the first renewal date by giving the Group Policyholder written notice at least sixty (60) days in advance. The Group Policyholder may also terminate this Group Policy by giving Us written notice at least sixty (60) days before the intended termination date. This Group Policy will also terminate if the required premium is not paid by the Group Policyholder as provided in the Grace Period provision.

Reinstatement: If any renewal premium is not paid by the end of the Grace Period, coverage under this Group Policy will be terminated. However, BEST Life will reinstate this Group Policy, without requiring an application for reinstatement, as long as premium is paid for at least the sixty (60) days prior to the date of

reinstatement. The reinstated policy will cover only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to sickness beginning ten (10) days after reinstatement. In all other respects the insured and BEST Life shall have the same rights as they had under the policy immediately before the due date of the defaulted premium, subject to conditions and provisions of the Policy.

PART 9 – GENERAL PROVISIONS

Clerical Error: Clerical error by the Group Policyholder shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated.

Third Party Responsibility: If an Insured is injured or becomes ill through the act or omission of another person, to the extent that the Insured recovers medical expenses for the same Injury or Illness from a third party or its insurer, We will be entitled to a repayment of any remuneration in excess of benefits paid under the Policy due to the same Injury or Illness, and after the Insured is fully compensated for his or her loss. We may file a lien for such repayment. Upon request, the Insured must complete and return the required forms to Us.

The repayment agreement will be binding upon the Insured, or the legal representative of a minor or incompetent, whether:

(1) the payment received from the third party, or its insurer, is the result of:
- legal judgment;
- an arbitration award;
- a compromise settlement;
- any other arrangements; or

(2) the third party or its insurer had admitted liability for the payment; or

(3) the dental expenses are itemized in the third party payment.

Entire Contract; Changes: The policy, including the endorsements, certificates, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. We will consider any statement made by the Insured or the Policyholder, in the absence of fraud, as a representation and not a warranty.

Underwriting Decisions: If, for any reason, We cannot accept Your application for coverage, We will communicate Our decision to You in writing with the reasons supporting Our decision.

Notification to Insureds: BEST Life will notify Subscriber in writing by mail to Subscriber's last known address at least thirty (30) days prior to the effective date of the termination of your insurance, a change in your premium, a change in eligibility or a change in your benefits. This notice will be given to the appropriate insurance producer and the appropriate administrator, if any, along with non-employee certificate holders or employees if more than one employer is covered under the policy.

Right to Contest: After this policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the policy) commencing after two (2) years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

Notice of Claim: We must receive written notice within twenty (20) days after a claim starts or as soon as reasonably possible. The notice shall be sent to BEST Life and Health Insurance Company at [2505 McCabe Way, Irvine, California 92614] or given it to Our agent.

Claim Forms: When We receive a notice of claim, We will send forms for filing the claim. If the Subscriber or Insured do not receive these forms within fifteen (15) days, the Subscriber or Insured may send Us a written statement to satisfy this requirement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the Proof of Loss provision.

Proof of Loss: We must receive written proof of loss within ninety (90) days of a claim. If it is not possible for proof to be provided within the ninety (90) days, We will not deny a claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless Subscriber is legally incapacitated.

Time of Payment of Claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: All payments will be made to Subscriber or Insured's provider.

Legal Actions: A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Time Limit on Certain Defenses: After this Group Policy has been in force for two (2) years, We will not use any statements made in the application of the Policyholder to void the Policy. After an Insured Person has been covered under this Group Policy for two (2) years, We will not use any statement made in the Insured Person's enrollment form to defend a claim.

Misstatement of Age: If the age of any individual covered under the Policy has been misstated, there shall be an adjustment of premium for the Policy so that there shall be paid to Us the premium for the coverage of such individual at his or her correct age, and the amount of the insurance coverage shall not be affected.

Worker's Compensation: The Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Conformity with State Statutes: Any provisions of the Policy which are in conflict with the statutes of the state in which the Policy was issued or delivered will be changed to conform to such laws.

Waiver of Rights: If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Policy.

Inspection of Group Policy: The Group Policy is in the possession of the Policyholder. It may be inspected at any time during business hours at the office of the Policyholder.

Duty to Cooperate: As a condition precedent to the payment of benefits hereunder, the Subscriber and

Insured are required to cooperate with Us by providing all information reasonably required to accurately process a claim. Any failure to provide necessary information may result in a denial of benefits for the claim.

CONTINUATION OF DENTAL COVERAGE: Federal Law (Public Law 99-272) requires Continuation of Dental Coverage for employers with 20 or more employees. Subject to the 20 employee requirement, You and Your Dependents who are covered under the group dental plan have the right to continue Your group dental coverage if it would terminate for the following specified reasons:

Comment [m1]: Required by TN law

(1) Termination of employment for any reason, except gross misconduct.
(2) Loss of dental plan eligibility due to reduced employment hours.
(3) Your employer files for a Chapter 11 reorganization;
(4) Your death.
(5) Your divorce.
(6) Your legal separation if You no longer make contributions for spouse or domestic partner coverage.
(7) A dependent child ceases to be a Dependent (i.e., reaches the maximum age, or becomes married, or is no longer a dependent for income tax purposes).
(8) A Dependent's loss of eligibility because You become entitled to Medicare Benefits.
(9) If You or Your Dependent would lose coverage due to one of the reasons in (5), (6), (7) or (8), You or Your Dependent must notify Us so We can give appropriate notice of Continuation rights and the terms which apply to the Continuation. For continuity of coverage, please give this notification within 30 days of the event.
(10) If You or Your Dependent elect the continued coverage and make the proper premium payment, the coverage would be continued until the earliest of:
    (1) the due date to pay any required premium (if premium is not paid by that date).
    (2) the date the continued person becomes covered under another group dental plan or entitled to Medicare Benefits.
    (3) the date the employer's group dental plan terminates. (If coverage is replaced, the Continuation is continued under the succeeding plan.)
    (4) a date which is:
        1. 18 months from the date coverage would have terminated because Your employment was terminated or eligibility was lost due to reduction in hours. However, if You are determined to have been disabled for Social Security purposes, You can continue coverage for 29 months from the date coverage terminated provided that notice of such determination of disability is given within 60 days and before the end of the 18-month continuation period.
        2. 36 months from the date coverage would have terminated, if coverage is continued for any other reason.

PART 10 – FILING A DENTAL CLAIM

HOW TO FILE A CLAIM: Claim forms may be obtained from [the BEST Life website located at www.bestlife.com, click on "Forms"].

Submit claims to [BEST Life and Health Insurance Company], [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

For questions about a claim payment, contact BEST Life's Customer Service at [1-800-433-0088 or at cs@bestlife.com, Monday through Friday, 7 am to 5 pm Pacific Time].

CLAIMS DENIAL PROCEDURE: Any denial of a claim for Benefits will be explained in writing. The explanation will include (a) the specific reason for the denial, (b) reference to the plan provision upon which the denial was based, (c) a description of any additional information that might be required to provide and an explanation of why it is needed, and (d) an explanation of the plan's claim review procedure.

APPEALING THE DENIAL OF A CLAIM: You or an authorized representative You appoint to assist or represent You, may appeal any denial of a claim, in whole or in part, for Benefits by filing a written request for a review. The request must include all reasons You believe the initial decision was incorrect and all documentation supporting Your appeal, to BEST Life and Health Insurance Company, Attn: Appeals, [P.O. Box 890, Meridian, ID 83680-0890, or Fax 208-893-5040].

A request for a review must be filed within one-hundred and eighty (180) days after the date on which we issue the written notice of denial of a claim. BEST Life and Health Insurance Company will provide an appeal determination not later than sixty (60) days after receipt of a request for review. If there are special circumstances, the decision will be made as soon as possible, but no later than fifteen (15) days after receipt of the request for review. The appeal determination will be in writing and will include specific reasons for the decision. This decision shall also include specific references to the Policy provisions on which the decision was based.

PART 11 - SUMMARY PLAN DESCRIPTION SUPPLEMENT

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA), and together with the rest of your Certificate, it forms the Summary Plan Description.

(1) NAME OF PLAN: [Beneficial Employees Security Trust], [P.O. Box 3100, Newport Beach, California 92658-9027].
(2) PLAN IDENTIFICATION NUMBER: [501].
(3) TYPE OF ADMINISTRATION AND TYPE OF WELFARE PLAN: The plan is administered by [BEST Life and Health Insurance Company] located at [2505 McCabe Way, Irvine, California 92614], [(800) 433-0088]. Benefits are insured in accordance with the Group Dental Insurance Policy issued by BEST Life.
(4) AGENT FOR SERVICE: The Chief Legal counsel of BEST Life at [the above address].
(5) TRUSTEE OF THE PLAN: [Wells Fargo Bank, N.A., 180 South Main Street, 2nd Floor, Salt Lake City, Utah 84101].
(6) SOURCE OF PLAN CONTRIBUTION: The contributions necessary to finance the plan are made by the employer and employees.
(7) DATE OF END OF THE PLAN'S FISCAL YEAR: [December 31].

PART 12 - STATEMENT OF ERISA RIGHTS

A Plan participant is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as follows:

(1) Examine, without charge, at the Administrative Representative's office and at other locations, such as work sites and union halls, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
(2) Obtain copies of all Plan documents and other Plan information upon written request to the Administrative Representative. The Administrative Representative may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Administrative Representative is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries.

No one, including a Participating Employer, union, or any other person, may fire or otherwise discriminate against an insured in any way to prevent the insured from obtaining a welfare Benefit or exercising rights under ERISA.

If a claim for a Welfare Benefit is denied in whole or in part, the Plan must provide a written explanation of the reason for the denial.

An insured has the right to have the Plan review and reconsider any claim.

Under ERISA, there are steps one can take to enforce the above rights. For instance, if one makes a request for materials from the Plan and does not receive them within 30 days, one may file suit in a federal court. In such a case, the court may require the Administrative Representative to provide the materials and pay up to $100 a day until it provides the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Representative. If one has a claim for Benefits which are denied or ignored, in whole or in part, one may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if one is discriminated against for asserting his or her rights, one may seek assistance from the U.S. Department of Labor, or one may file suit in a federal court. The court will decide who should pay court costs and legal fees. If one is successful, the court may order the person sued to pay these costs and fees. If one loses, the court may order that person to pay these costs and fees.

If one has questions about a Plan, he or she should contact the Administrative Representative. If one has questions about this statement or about rights under ERISA, he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

VARIABILITY STATEMENT

GPD-PPO-POL-0113TN

Title Page – The address and officers of the company may change; Policy.

Page 2 – The President and Secretary of the company may change.

Page 3 – Specific to the Client.

Policyholder – Is the trustee of the Beneficial Employees Security Trust of Utah. Is bracketed in case the name of the trust changes.

Schedule of Benefits – we are offering two plan designs. We have provided the full range of possibilities that would apply. In the final Certificate, only the plan that was selected will appear.

General Provisions

- **Notice of Claim** – Address may change.

Filing a Dental Claim

- How to file a claim – URLs and contact information are bracketed to allow for changes, and possibly a third party administrator. Right now, there is no contract with a third party administrator, so BEST Life's current contact information is provided.
- Appealing the denial of a claim – address may change.

GPD-PPO-CERT-0113TN

Title Page –The address of the company may change.

Page 2 – The President and Secretary of the company may change.

Statement of Coverage – Group and Insured information will be provided in the bracketed fields.

- **Subscriber Name –** Specific to individual purchasing the plan.
- **Certificate Effective Date –** Specific to the plan year for the Exchange.
- **Insured name(s) and Effective Dates(s) –** specific to client.
- **Participating employer name and number –** specific to the client.
- **Plan information** – We are transitioning to a new administrative system. Our current administrative system provides plan selection information in the Statement of Coverage. The new administrative system will provide this information in the Schedule of Benefits. The Plan, Deductible, and Annual Maximum is bracketed because these fields will no longer be provided once the new system is up and running.
- **Group Policy Number** – Specific to the client.

Policyholder – Is the trustee of the Beneficial Employees Security Trust of Utah. Is bracketed in case the name of the trust changes.

Schedule of Benefits – we are offering two plan designs. We have provided the full range of possibilities that would apply. In the final Certificate, only the plan that was selected will appear.

General Provisions

- **Notice of Claim** – Address may change.

Filing a Dental Claim

- How to file a claim – URLs and contact information are bracketed to allow for changes, and possibly a third party administrator. Right now, there is no contract with a third party administrator, so BEST Life's current contact information is provided.
- Appealing the denial of a claim – address may change.

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[PPO] Dental Plans Employer Application

2505 McCabe Way, Irvine, CA 92614
Requested Effective Date: ☐ 1st or ☐ 15th of the month _____, 20____

Type of Coverage Requested	Supplemental Dental Plans				Essential Pediatric Plans	
Select dental plan	☐ [High]	☐ [Mid]	☐ [Basic]	☐ [Value]	☐ [High]	☐ [Low]
Calendar Year Deductible (Applies to Basic and Major Services)	$50	$50	$50	$50	In $0 Out $50	In $50 Out $100
Maximum Benefit Level	In $1,500 Out $1,500	In $1,500 Out $1,500	In $1,000 Out $1,000	In $1,000 Out $1,000		
Out-of-Pocket Maximum					In $700 Out $1,400	In $700 Out $1,400
Preventive Care Services	In 100% Out 100 %	In 100% Out 80 %	In 100% Out800 %	In 100% Out 80 %	In 100% Out 90%	In 100% Out 60%
Basic Services	In 90% Out 80%	In 80% Out 80%	In 80% Out 50%	In 50% Out 20%	In 70% Out 60%	In 55% Out 40%
Major Services	In 60% Out 50%	In 50% Out 50%	In 0% Out 0%	In 0% Out 0%	In 50% Out 40%	In 35% Out 200%
Endodontics	Basic	Basic	Basic	Basic	Major	Major
Periodontics	Major	Major	Major	Major	Major	Major
Child Orthodontics	$1,000 Lifetime	$1,000 Lifetime	$1,000 Lifetime	$1,000 Lifetime	Medically Necessary	Medically Necessary
Reimbursement Level	80th Percentile	80th Percentile	80th Percentile	80th Percentile	80th Percentile	80th Percentile
Employer Choice Option	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Voluntary Option	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

** Employer is contributing less than 50% for each employee. **Certain requirements apply. Please see Plan Brochure for details.*

EMPLOYER/EMPLOYEE INFORMATION

On Payroll	Full-Time	Eligible	Enrolling	Description of Classes not Eligible

Are any employees applying for coverage currently receiving extended benefits under COBRA? ☐ Yes ☐ No *(If yes, please list names below.)*

The Firm's Waiting Period waived for Present Employees? ☐ Yes ☐ No

All new employees are eligible the first of the month following continuous full-time employment of: ☐ 1st of the month following date of hire
☐ 1 Full Calendar Month (standard) ☐ 2 Full Calendar Months ☐ 3 Full Calendar Months

Employer Contribution _____ % for employees _____ % for dependents *(Note: on employer-sponsored plans, Employer must pay at least 50% for employees.)*

Does Employer have proof of comparable group dental insurance for the past twelve (12) consecutive months? ☐ Yes ☐ No *(A copy of your most recent dental bill listing the covered employees and their effective dates must accompany this application.)*

[Supplemental Dental Only: The 12-month wait on Major and Ortho services is waived for employees and groups based on group size and proof of prior coverage for 12 consecutive months on a comparable group dental plan as follows: Employer-sponsored plans: employees with proof of prior coverage only, who are in a group with prior coverage and 5-9 employees enrolled; all employees in a group with 10+ employees enrolled.
Voluntary plans: employees with proof of prior coverage only, who are in a group with prior coverage and 5-9 employees enrolled; all employees in a group with prior coverage, with 10-24 employees enrolled and 50% participation; if 50% participation is not met, waiver will only apply to employees with proof of prior coverage.]

EMPLOYER ACKNOWLEDGEMENT & ASSOCIATION AND TRUST SUBSCRIBER AGREEMENT

Employer Name				Employer Federal Tax Number	
				( ) -	( ) -
Street Address	City	State	Zip	Telephone Number	Fax Number

Billing Address / P.O. Box	City	State	Zip	Email

Nature of Firm's Business	SIC Code	Firm's Contact for Service and Administration of the Selected Plans

I certify that this is a bona fide business with a legitimate business purpose and which has a true employer-employee relationship with the individuals designated as employees. I understand that any false statements made in this application constitute the legal basis for termination or cancellation of coverage retroactive to the effective date and denial of all claims incurred.

I understand and agree that the insurance hereby applied for is not effective until this application and the full initial premium is delivered to, received by and approved by BEST Life and Health Insurance Company.

Termination of Coverage—Employee coverage and dependent coverage will terminate on the earliest of the following dates: (1) the date the employee ceases to be an eligible employee or the date the dependent is no longer eligible as a dependent under the plan; (2) the date the plan is terminated; (3) the date the employer terminates the coverage by failing to pay the required premium; (4) the date the group policy is terminated; (5) the date the group no longer meets minimum participation requirements. The benefits are subject to all the conditions and limitations of the plan.

Eligible dependent coverage terminates on the earliest of the following: (1) when the dependent no longer meets the definition of a dependent; (2) on the first day of the month in which premiums were not paid; or (3) when the member terminates coverage.

FIRM ELIGIBILITY:

A firm or employer must be an active business operation to request coverage. The business must continue on an active basis to retain eligibility for coverage. Coverage will be terminated on the effective date the business ceases active operation. I understand that if my firm drops in size to 1 employee, and if additional employees are not enrolled and active for coverage within 2 months, all of my selected insurance coverage will be cancelled.

IMPORTANT PLAN INFORMATION

The undersigned Employer understands and agrees that it is establishing an employee welfare benefit plan for its employees. The Employer further understands and agrees that the general definition of an employee is a person who usually works at least 30 hours per week at the firm's business location with federal, state and social security tax withheld from their salary.

The Employer understands that by signing this Trust Subscriber Agreement, it is subscribing to a trust group insurance policy for which Beneficial Employees Security Trust of Utah ("B.E.S.T.") is the Master Group Policy policyholder, which is sponsored by the BEST Employers Association ("BEA") to which the Employer joins. B.E.S.T. receives the subscribing Employer's payment and remits the insurance premium(s) to the insurance carrier(s) or to affiliates, Beneficial Administration and BEST Health Plans that provide services to subscribing employers and to B.E.S.T. One of the insurance carriers is BEST Life and Health Insurance Company ("BEST Life").

The Employer understands that by signing this Trust Subscriber Agreement it shall be bound to all the terms and conditions of the Declaration of Trust, including an agreement that the Trustee shall not be liable to any subscribing employer, to any person insured, or to anyone else in connection with the operation of the Group Insurance Trust Fund. The Master Group Policy is governed by the laws of the state of Utah. However, to the extent that such Policy and/or Certificate of Insurance is in conflict with the laws of another demonstrating statutory governing jurisdiction over an out-of-state multiple employer trust Policy, then such Policy and/or Certificate of Insurance may be amended to comply with the minimum requirements of that State.

The Employer understands that by signing this Trust Subscriber Agreement, it becomes a member of BEA and a $2.00 monthly due will be charged along with the insurance premium for the plan(s) the Employer selects. This will also provide access to benefits offered by BEA and may vary by availability, vendor, or state of residence of the participating employer.

FRAUD NOTICE – The following general Fraud Notice is intended to comply with the laws of your state. If any part of such language is found in conflict, such language shall be construed as amended to the extent necessary in order to meet the minimum requirements of your state. Any person who, knowingly and with intent to defraud or deceive any insurance company, files an application containing any materially false, incomplete or misleading information may be guilty of committing a fraudulent insurance act which is a crime and may be subject to criminal prosecution.

X / /

Signature of Company Officer | Print Name & Title | Dated

If using a navigator, navigator's signature required on following page.

GAD-PPO-EAP-0113TN

NAVIGATOR REPORT

(Please Print)

Name _____

It is not necessary to complete the following information if you are currently receiving service fees from BEST Life unless changes in address, etc. need to be made. Please sign and date the form below.

Your Agency Name

Address

City | State | Zip

Who Should Receive the Service Fees? ☐ Navigator ☐ Company/Firm

Social Security Number | Federal Tax ID

Date of Birth | License No. | State

Phone No. | FAX No.

Email Address

(Please Complete)

Special Instructions to BEST Life

1. May we contact the client if we need additional information?
   ☐ Yes ☐ No
2. Is this your first case with BEST Life? ☐ Yes ☐ No
3. This is: ☐ an existing client ☐ a new client with my company
4. Send 'New Client Kit' (certificate book, claim forms, etc.) to:
   ☐ The Navigator ☐ The Client
5. The underwriter assigned to my case should contact me?
   ☐ Yes ☐ No

General Agent (GA):

Please list any special handling needed for this client:

I hereby certify that I hold a valid Life, Accident and Health license issued by the state in which this document was executed and that all of the information contained herein is correct, to the best of my knowledge, and that I know nothing unfavorable about this firm or any individual applying for insurance unless fully described in this application material. Furthermore, I certify that:

1. This firm is a bona fide business establishment and participation requirements are being met.

2. I have advised my client not to terminate any existing coverage until this coverage is approved.

3. Coverage, eligibility provisions, waiting periods and limitations have been fully explained to, and understood by, the Employer identified in this document.

4. I have no right to bind, modify or alter provisions of this program.

I understand and agree that the insurance applied for herein does not begin until this application is received and approved by BEST Life and Health Insurance Company, the insurance certificates are issued and the first premium is received and accepted.

Navigator's Signature:	Print Name:	Date:

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Rate Information

Rate data applies to filing.

Filing Method:	Upon Approval
Rate Change Type:	Neutral
Overall Percentage of Last Rate Revision:	0.000%
Effective Date of Last Rate Revision:	01/01/2014
Filing Method of Last Filing:	New product

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
BEST Life and Health Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		ACTUARIAL MEMO	GAD-PPO-POL-0113TN, GPD-PPO-POL-0113TN	New		Actuarial Memorandum TN - Group April 30 2013.pdf,
2		PEDIATRIC RATE CALCULATIONS	GPD-PPO-POL-0113TN	New		Group Pediatric - TN 04302013.pdf,
3		ADULT RATE CALCULATIONS	GAD-PPO-POL-0113TN	New		Group Supplemental - TN 04302013.pdf,

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Actuarial Memorandum

Scope and Purpose

This is a new product rate filing to satisfy the Stand-Alone Adult and Pediatric Dental Plans Rate Filing requirements for the Tennessee Health Benefit Plan under group policy numbers GPD-PPO-POL-0113TN and GAD-PPO-POL-0113TN.

Description of Benefits

The policies provide benefits for two small group stand-alone dental products: a Pediatric Dental Only Plan and an Adult Dental Plan. These plans are designed to be offered either through the Beneficial Employees Security Trust of Utah, which is situated in the State of Utah. These plans will be marketed to employer groups through the Tennessee SHOP Exchange market.

Children to age 20 are eligible to enroll on the Pediatric Dental Only Plan. Adults and child dependents age 21 through age 25 are eligible for coverage as long as the adults are full-time employees, or part-time employees if the employer so chooses.

Benefit Renewability

The policies are standard group contracts, to be issued to employer-sponsored groups and group associations. Coverage for individuals is renewable at the option of the policyholder. The Company reserves the right to increase premiums.

Proposed Effective Date

January 1, 2014

Description of Rate Calculations

- Base claim costs are developed using our company California claims experience from 2010 to 2012.
- Base claim costs are adjusted to reflect the plan design and adjusted for area using the 2010 HealthMaps Dental Rate Manual and Milliman study dated November 2012.
- A dental trend factor of approximately 4% per year is used to project future expected claims and is included in the premium rate structure
- Standard company retention of 30.75% (administration – 12%, premium tax – 1.75%, user fees – 3.5%, commissions – 10% and profit – 3.5%) is applied.

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Anticipated Future Loss Ratio

The anticipated future loss ratio for this policy is expected to be 69.25%. The loss ratio is computed as follows:

$$\text{Loss Ratio} = \frac{\text{Expected Incurred Claims}}{\text{Expected Earned Premium}}$$

Incurred claims are total claims for covered expenses paid on behalf of a covered person while coverage is in force, summed for all covered persons. Earned premium is the premium for each covered person for the period coverage is in force, summed for all covered persons.

I, Adam S. Chan, Actuary for BEST Life and Health Insurance Company ("BEST"), NAIC #90638, domiciled in Texas, do hereby certify that to the best of my knowledge and judgment, this rate submission is in compliance with the applicable laws and regulations of Tennessee and all applicable Actuarial Standards of Practice, including ASOP No. 8, and that the attached rates are reasonable in relation to the benefits provided and are not excessive, inadequate, or unfairly discriminatory.

Adam Chan, A.S.A., M.A.A.A.
Corporate Actuary
BEST Life and Health Insurance Company
Irvine, California

April 30, 2013
Date

BEST Life and Health Insurance Company

Tennessee Health Insurance Exchange Rate Filing

Small Employer Group Dental - Essential Pediatric Plans

	High Plan - Actuarial Value 84%		Low Plan - Actuarial Value 69%	
	1 child	2 or more child	1 child	2 or more child
Base Cost	$ 57.35	$ 112.60	$ 50.59	$ 99.34
Trend	1.12	1.12	1.12	1.12
Area factor	0.80	0.80	0.80	0.80
Net Cost	$ 51.55	$ 101.21	$ 45.48	$ 89.29
Administrative	12.00%	12.00%	12.00%	12.00%
Premium Tax	1.75%	1.75%	1.75%	1.75%
User Fees*	3.50%	3.50%	3.50%	3.50%
Broker Commission	10.00%	10.00%	10.00%	10.00%
Profit	3.50%	3.50%	3.50%	3.50%
Target Loss Ratio	69.25%	69.25%	69.25%	69.25%
Final Rate*	$ 74.44	$ 146.16	$ 65.67	$ 128.94

** User fees of 3.5% imposed by the Department of Health and Human Services are included.*

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Tennessee Health Insurance Exchange Rate Filing

Small Employer Group Dental - Supplemental Plans

	High Plan	Mid Plan	Basic Plan	Value Plan
Base Cost	$ 75.21	$ 67.08	$ 46.96	$ 30.67
Trend	1.12	1.12	1.12	1.12
Area factor	0.80	0.80	0.80	0.80
Net Cost	$ 67.61	$ 60.30	$ 42.21	$ 27.57
Administrative	12.00%	12.00%	12.00%	12.00%
Premium Tax	1.75%	1.75%	1.75%	1.75%
User Fees*	3.50%	3.50%	3.50%	3.50%
Broker Commission	10.00%	10.00%	10.00%	10.00%
Profit	3.50%	3.50%	3.50%	3.50%
Target Loss Ratio	69.25%	69.25%	69.25%	69.25%
Final Voluntary Tier Rates*				
Employee	$ 107.78	$ 96.13	$ 67.29	$ 43.96
Employee + Spouse	$ 219.85	$ 196.10	$ 137.26	$ 89.66
Employee + Children	$ 231.57	$ 206.55	$ 144.57	$ 94.44
Employee + Family	$ 375.37	$ 334.81	$ 234.35	$ 153.09
Final Employer-Contributory Tier Rates*				
Employee	$ 94.84	$ 84.60	$ 59.21	$ 38.68
Employee + Spouse	$ 193.47	$ 172.57	$ 120.79	$ 78.90
Employee + Children	$ 203.78	$ 181.76	$ 127.22	$ 83.11
Employee + Family	$ 330.32	$ 294.63	$ 206.23	$ 134.72

** User fees of 3.5% imposed by the Department of Health and Human Services are included.*

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Supporting Document Schedules

Satisfied - Item:	Cover Letter Accident & Health
Comments:	Please see General Information Description Tab for details.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Description of Variables
Comments:	Plan ranges are included in the Certificates and policies as instructed.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Filing Fees
Bypass Reason:	Paid by EFT.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	Readability Certification_Ex.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Third Party Authorization
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Group Rates Certification/Memo - Accident & Health

SERFF Tracking #:	*BLHI-129004056*	***State Tracking #:***	*H-130558*	***Company Tracking #:***	*FORM FILING*

State:	*Tennessee*	***Filing Company:***	*BEST Life and Health Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Group Stand Alone Dental*		
Project Name/Number:	*Form Filing/Exchange Products*		

Bypass Reason:	Included with Actuarial Memorandum.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Accident & Health Group Rates non-experience
Bypass Reason:	Please see the Rate Manual included under the Rate Tab.
Attachment(s):	
Item Status:	
Status Date:	

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Readability Certification

Certification by an Officer of the Company

Persuant to TCA 56-7-1605(a)(1) and TCA 56-7-1605(e), I, Paul Peatross, am the President for the BEST Life and Health Insurance Company. I certify that the forms in this filing have been tested and meet the minimum required reading ease score.

Each form has a score of 43.5.

Signature of the Officer

4/30/2013

Date